

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

06404

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deanwood Park		c. LENGTH OF STAY IN lb 5 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1117 Eastern Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ronald Middle Adair Last		4. DATE OF DEATH Month June Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Jan., 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 5 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Floyd Adair		14. MOTHER'S MAIDEN NAME Estelle Briscoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Estelle Adair		Address # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Diffuse bronchopneumonia (c) 491X DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED 27 June 1956	
EXAMINER'S NAME (Type) John T. Maloney: M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 30, 1956	
22c. NAME OF CEMETERY OR CREMATORY WOOD LAWN		22d. LOCATION (City, town, or county) (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE M. K. Rollins		24a. REC'D BY REGISTRAR 7-1-56	
ADDRESS 4339 Howard Pl. NE		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06405

Reg. Dist. No.

6426

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont 15x-2 ✓</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>			d. STREET ADDRESS <u>6102 Broad Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>L.</u> Last <u>Anderson</u>			4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Trege</u>			14. MOTHER'S MAIDEN NAME <u>Mary Sullivan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hyattsville, Md.</u> <u>Margaret Kremer, 5321 Greenway Drive</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don, DeVol</u>		ADDRESS <u>2224 Wis. Ave.</u> <u>Washington, 7 D.C.</u>		24b. REC'D BY REGISTRAR DATE <u>JUL 3 1956</u>		
24c. REGISTRAR'S SIGNATURE <u>J. W. B. Bouch</u>						

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

6491

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Clinton		c. LENGTH OF STAY IN 1b 20 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Clinton,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piscataway Road			d. STREET ADDRESS Piscataway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Mary Last Ashe			4. DATE OF DEATH Month June Day 25 Year 19 56		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hous ewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John P. Cissel			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Mida Geigler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Frank Cissel - Brother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 10 HRS. 153 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA OF LIVER 7 MOS. DUE TO (c) ORIGINAL SITE - CECUM UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour o. m. NONE 19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	
20f. (City or town) CLINTON, M.D.		20g. (County) CLINTON, M.D.		20h. (State) MARYLAND	
21. I certify that I attended the deceased from June 5th 1956 , to June 25, 1956 , that I last saw the deceased alive on June 25th 1956 , and that death occurred at 4:13 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Arthur Shaver Jr.		ADDRESS (Street, city or town, state) CLINTON, M.D.		DATE SIGNED JUNE 25, 1956	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR		ADDRESS CLINTON, M.D.		DATE JUNE 25, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	
22d. LOCATION (City, town, or county) Arlington, Virginia		22e. (State) VA			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE 28 1956	
24b. REGISTRAR'S SIGNATURE Mrs. Carrie Campbell					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John F. Jones		2. SEX Male		3. AGE 45	
4. DATE OF DEATH June 2, 1956		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Baltimore, Md.		8. OCCUPATION Teacher		9. MARITAL STATUS Married	
10. NAME OF PHYSICIAN Dr. J. H. Smith		11. NAME OF FUNERAL HOME None		12. SIGNATURE OF DECEASED None	
13. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		14. SIGNATURE OF FUNERAL HOME None		15. SIGNATURE OF DECEASED None	

BUREAU V. 2

JUN 28 1956

RECEIVED

16. NAME OF DECEASED John F. Jones		17. SEX Male		18. AGE 45	
19. DATE OF DEATH June 2, 1956		20. PLACE OF DEATH Home		21. CAUSE OF DEATH Heart Disease	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6415

CERTIFICATE OF DEATH

06408

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kirkwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2716-Kirkwood Place</u>		d. STREET ADDRESS <u>2716-Kirkwood Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Kenny</u> Middle <u>Baker</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11/79</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. retired Dept. Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Middleburg, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thos. R. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Mary English</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-034583</u>	
17. INFORMANT <u>Vila H. Baker</u> Address <u>Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longestive Heart failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cor pulmonale</u> DUE TO (c) <u>Pulmonary emphysema, severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>1 yr.</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 8</u> , 19 <u>54</u> , to <u>June 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>56</u> , and that death occurred at <u>7:17</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Kelly</u>		DATE SIGNED <u>6/24/56</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u>		ADDRESS (Street, city or town, state) <u>6480 7. H. Ave., Takoma Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mally's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>M.D.</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

CERTIFICATE OF DEATH

[Faint, illegible text from the reverse side of the document is visible through the paper.]

1

BUREAU V. S.

JUL 2 1956

RECEIVED

1956

411

[Handwritten signature]

RECEIVED JUL 2 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Cheverly</u>				c. LENGTH OF STAY IN 1b <u>PNOS. DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>3910 Allison Street</u>							
3. NAME OF DECEASED (Type or print) First <u>Debra</u> Middle <u>Theresa</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1956</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Walter Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Laura Blanche Baker</u> (Mother)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Laura B. Baker 3910 Allison St., N. Brentwood</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				DATE SIGNED <u>June 24, 1956</u>			
EXAMINER'S NAME (Type) <u>John T. Maloney</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest J. Gorn's Co</u>				24a. REC'D BY REGISTRAR <u>W. B. Baker</u>			
ADDRESS <u>1432 2nd St. N.W.</u>				DATE <u>JUL 5 1956</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The form is mostly blank with some faint markings and a large vertical crease down the center.

RECEIVED
JUL 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06410

6492

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 310 47th St., N. E.	
3. NAME OF DECEASED (First) (Middle) (Last) MACK BAKER		4. DATE OF DEATH (Month) (Day) (Year) 6 12 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 3/20/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Had On Farm - '36	9. AGE last birthday 76 yrs.
11. BIRTHPLACE (State or foreign country) Rock Mount, N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Baker		14. MOTHER'S MAIDEN NAME Rosetta B. Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Decedent			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) 002X Pulmonary Tuberculosis			3 yrs
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/25, 1955, to 6/12, 1956, that I last saw the deceased alive on 6/11, 1956, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

SIGNATURE Francis Stasko M.D.		ADDRESS Glenn Dale Hospital		DATE SIGNED 6/12/56
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE 6-12-56	NAME OF CEMETERY OR CREMATORY Washington	LOCATION (City, town, or county) D.C.	(State)
DATE REC'D BY LOCAL REG. 6/12/56	REGISTRAR'S SIGNATURE Woe Weir	24. FUNERAL DIRECTOR Morgan & Woodford	ADDRESS 1622 11th St NW	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06411

Item 7, Film G199 6-21-56 et

6428

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38</u> <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>85 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77</u> <u>Prince George General Hospital</u>			d. STREET ADDRESS <u>6828 Roosevelt Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Barfrede</u> Last <u></u>			4. DATE OF DEATH Month <u>11</u> Day <u>June</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Feb. 1894</u>		9. AGE (In years lost birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Ransom Lewis Main</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>Mrs Irwin I. Main</u>			Address <u>Seat Pleasant Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170x</u> <u>Immaculation Congestive Heart Failure</u> DUE TO <u>adenocarcinoma of right breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>c metastasis.</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>56</u> to <u>6/11</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6/11</u> , 19 <u>56</u> and that death occurred at <u>5.00A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D. <u>6304 Annapolis Rd</u>			DATE SIGNED <u></u>		
PHYSICIAN'S NAME (Type) <u>DAYTON O WATKINS</u> <u>Bladenburg md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>			ADDRESS <u>Hvattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-15-56</u>
					24b. REGISTRAR'S SIGNATURE <u>A.W. Heuch</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. PLACE OF DEATH	
JAMES EARL RAY		Male		35		White		Memphis, Tennessee		Baltimore, Maryland	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
Salesman		Myocardial Infarction		Natural		June 15, 1956		10:15 AM		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CLERK		16. SIGNATURE OF CHIEF OF BUREAU		17. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		18. SIGNATURE OF DEPUTY CHIEF OF BUREAU	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUN 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429

CERTIFICATE OF DEATH

06412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>1921 Hamlin St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Payne</u> Last <u>Beach</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/89</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Cornelius Beach</u>			
14. MOTHER'S MAIDEN NAME <u>Freddie Payne</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u>217-07-5804</u>				17. INFORMANT <u>H.P. Beach, Jr.</u> Address <u>3249 Arcadia Place, N.W.</u> Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Hepatic Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the liver</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Prostatectomy for Carcinoma of Prostate</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 25, 1956</u> , to <u>6-22, 1956</u> , that I last saw the deceased alive on <u>6-22, 1956</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Waldo B. Moyers</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Pennsylvania St. N.W. Washington, D.C.</u>			
DATE SIGNED <u>6-22-56</u>				PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>6/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 98 6-13-56 et

6430

CERTIFICATE OF DEATH

Reg. Dist. No. 06413/

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY PG		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg, Md.		c. LENGTH OF STAY IN 1b 15 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3421-40th Place X	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges Gen. Hosp.			d. STREET ADDRESS Colman Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Last Bickford			4. DATE OF DEATH June 7, 1956		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1890		9. AGE (In years less birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech. Engg.		10b. KIND OF BUSINESS OR INDUSTRY Navy Supt		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Robert L Bickford			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Statistic Card

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of esophagus with acute mediastinitis and spillage of gastric contents into pleural spaces. 541.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute gastric dilatation (c) Duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-6, 1956, to 6-7, 1956, that I last saw the deceased alive on 6-7, 1956, and that death occurred at 7-PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Samuel J Sugar M.D. ADDRESS (Street, city or town, state) Md Baltimore DATE SIGNED 6/7/56

PHYSICIAN'S NAME (Type) SAMUEL J SUGAR

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6/11/56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colman Manor, Md
23. FUNERAL DIRECTOR'S SIGNATURE F. Zascha Sons & Co		24a. REC'D BY REGISTRAR DATE 6-11-56	24b. REGISTRAR'S SIGNATURE A.W. Souch

3. A. 1000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06414

6431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Pr. George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen Hospital		d. STREET ADDRESS 509 - 70th St.	
3. NAME OF DECEASED (Type or print) First James Middle H. Last Brady		4. DATE OF DEATH Month June Day 29th Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1889
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Ret Naval gun factory	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Brady		14. MOTHER'S MAIDEN NAME Brady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Laura. E. Brady-509 70th St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X hemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sarcoma of Bladder DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1956 , to June 29, 1956 , that I last saw the deceased alive on June 29, 1956 , and that death occurred at 5:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William Brainin M.D. 6124 Central Ave 6/29/56			
ACTUAL SIGNATURE William Brainin		PHYSICIAN'S NAME (Type) WILLIAM BRAININ	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-56	
22c. NAME OF CEMETERY OR CREMATORY Addison Chapel		22d. LOCATION (City, town, or county) (State) Seat Pleasant Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons		ADDRESS 300 - 4 St N.E.	
24a. REC'D BY REGISTRAR DATE 7/1/56		24b. REGISTRAR'S SIGNATURE R. G. Rouch	

RECEIVED

JUL 2 1956

BUREAU V. S.

2025

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME: [REDACTED]
AGE: [REDACTED]
SEX: [REDACTED]
RACE: [REDACTED]
DATE OF BIRTH: [REDACTED]
PLACE OF BIRTH: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE: [REDACTED]
DATE: [REDACTED]

6432

CERTIFICATE OF DEATH

06415

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		e. STREET ADDRESS 5221 42th Place	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ethel Bragg		4. DATE OF DEATH Month Day Year June 30, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Preston Eubank		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-09-3333	
17. INFORMANT Hospital Records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x CEREBRAL Infarction DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 Days 8 Days. 9 Days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and Bronchial asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1956 to June 30, 1956 that I last saw the deceased alive on June 30, 1956, and that death occurred at 7:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) 4300 Layman Dr MT PLAIN, Md.	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		DATE SIGNED June 30, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE 3 1956		24b. REGISTRAR'S SIGNATURE R. A. R. R. R.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956 3 JUL

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06416

6433

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 4606 - 29th. street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Maria S Brito		4. DATE OF DEATH Month Day Year June 24, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 11, 1911
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY American Oil Co.	
11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Fernandez		14. MOTHER'S MAIDEN NAME Maria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT John B. Sheehan		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Generalized Carcinomatosis Carcinoma of Cervix Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1956, to June 24, 1956, that I last saw the deceased alive on June 24, 1956, and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar		DATE SIGNED 6/24/56	
M.D. 4300 Kaywood Dr. Mt. Rainier Md.			
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Coenma Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.		ADDRESS Mt. Rainier Md.	
24a. REC'D BY REGISTRAR DATE June 25, 1956		24b. REGISTRAR'S SIGNATURE B. C. C. C.	

CERTIFICATE OF DEATH

Name of Deceased		John P. Shes an	
Sex		Male	
Age		40 - 50	
Date of Death		1956	
Place of Death		Baltimore, Maryland	
Cause of Death		Heart Disease	
Occupation		Salesman	
Residence		Baltimore, Maryland	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

I hereby certify that the above is a true and correct statement of the facts as reported to me by the attending physician and the informant.	
Signature of Registrar	
Date	
Place	

RECEIVED
JAN 27 1956
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06418

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>402 Chillum Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> d. STREET ADDRESS <u>402 Chillum Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cyril Sherman</u> First Middle Last 4. DATE OF DEATH Month Day Year <u>June 13 1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 19, 1895</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sherman Brown</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 1</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hazel Brown, Same address as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 13, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>June 14 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Berere</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 13, 14 Film 202 9-4-56 et

6435

CERTIFICATE OF DEATH

08557

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chenery</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Md.</u> 33					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Prince Georges Gen Hosp.</u>				d. STREET ADDRESS <u>4903-49th St</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Brown</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-77</u>			
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.					
17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Probable Carcinoma of Stomach - metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 months</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>5-18, 1956</u> to <u>6-12, 1956</u> , that I last saw the deceased alive on <u>6-12, 1956</u> , and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>A. B. Passer</u>				ADDRESS (Street, city or town, state) <u>Upper Marlboro Md</u>					
PHYSICIAN'S NAME (Type) <u></u>				DATE SIGNED <u>6-13-56</u>					
22a. BURIAL (CREMATION, REMOVAL (Specify)) <u>Removal</u>				22b. DATE THEREOF <u>6-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>			
22d. LOCATION (City, town, or county) <u>Baltimore</u>				(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blanch W. Smith</u>				ADDRESS <u>Pr. Geo. Gen Hosp. Chenery, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-13-56</u>			
24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>									

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE	
EDUCATION		OCCUPATION	
RELIGION		RACE	
SEX		COLOR	
MANNER OF DEATH		CAUSE OF DEATH	
IMMEDIATE CAUSE OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06419

6436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cherevely</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 day Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13 Prince Geo Gen. Hosp.</u>				d. STREET ADDRESS <u>4409-3 Greenbury Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Fredrick</u> Last <u>BUSH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-13</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ERECO.</u>		11. BIRTHPLACE (State or foreign country) <u>N. J. NEWARK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frederic Shites Bush</u>				14. MOTHER'S MAIDEN NAME <u>Edna Mae Nauhoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>135-03-2197</u>		17. INFORMANT <u>Ann M. Bush</u> Address <u>86 East St Doylestown Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>414X Rheumatic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>? Subacute bacterial Endocarditis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>June 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>56</u> , and that death occurred at <u>6:07</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Lear</u> M.D.				ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville Md</u>			
DATE SIGNED <u>6-4-56</u>							
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Chambers Co.</u> ADDRESS <u>Riverdale Md</u>				24a. REC'D BY REGISTRAR <u>JUN 8 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Shovich</u>	

BUREAU

8 Nov 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06420

6437

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.B.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>3219 Dumwood Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>Bo</u> Middle <u>Ca</u> Last <u>ho</u>		4. DATE OF DEATH <u>June 6, 1956</u> Month <u>June</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1956</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ca ho, Robert</u>		14. MOTHER'S MAIDEN NAME <u>Shreves, Alma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interventricular Septal Defect</u> DUE TO (c) <u>Congenital Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1956</u> , to <u>June 6, 1956</u> , that I last saw the deceased alive on <u>June 6, 1956</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Prince Georges G. n. Hosp., Cheverly, 6-7-56</u>			
DATE SIGNED			
ACTUAL SIGNATURE <u>Cornelius J. Burns, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Cornelius J. Burns, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Stoeckel</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>A. W. Hedrick</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
DATE <u>6-12-56</u>			

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND—BALTIMORE, 18

6438

CERTIFICATE OF DEATH

06421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Md - 2 weeks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>3905 Kennedy St.</u>			
3. NAME OF DECEASED (Type or print) <u>Virgil</u> First <u>Carneal</u> Middle Last				4. DATE OF DEATH <u>June 25, 1956</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1878</u>		9. AGE (In years last birthday) <u>82 1/2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Virgil Carneal</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-48-5257A</u>		17. INFORMANT <u>Mrs. Ildria B Carneal</u> Address <u>Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Surgery (2 weeks ago) for gangrene of the small intestine</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-11</u> , 19 <u>56</u> , to <u>6-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>56</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.		ADDRESS (Street, city or town, state) <u>1432 QUEENSCHAPEL RD.</u> DATE SIGNED <u>6/25/56</u>					
PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		<u>Hyattsville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Place of birth		6. Date of death	
7. Cause of death		8. Manner of death		9. Place of death	
10. Signature of physician		11. Signature of registrar		12. Signature of informant	
13. Date of registration		14. Registrar's office		15. Registrar's name	
16. Registrar's address		17. Registrar's telephone		18. Registrar's fax	
19. Registrar's email		20. Registrar's website		21. Registrar's social media	
22. Registrar's contact information		23. Registrar's office hours		24. Registrar's fees	
25. Registrar's policies		26. Registrar's procedures		27. Registrar's regulations	
28. Registrar's rules		29. Registrar's laws		30. Registrar's orders	
31. Registrar's decrees		32. Registrar's edicts		33. Registrar's mandates	
34. Registrar's commands		35. Registrar's prohibitions		36. Registrar's restrictions	
37. Registrar's limitations		38. Registrar's exemptions		39. Registrar's dispensations	
40. Registrar's licenses		41. Registrar's permits		42. Registrar's certificates	
43. Registrar's diplomas		44. Registrar's degrees		45. Registrar's honors	
46. Registrar's awards		47. Registrar's medals		48. Registrar's ribbons	
49. Registrar's sashes		50. Registrar's cords		51. Registrar's chains	
52. Registrar's orders		53. Registrar's decorations		54. Registrar's insignia	
55. Registrar's emblems		56. Registrar's crests		57. Registrar's coats of arms	
58. Registrar's flags		59. Registrar's banners		60. Registrar's standards	
61. Registrar's pennants		62. Registrar's streamers		63. Registrar's bunting	
64. Registrar's festoons		65. Registrar's garlands		66. Registrar's wreaths	
67. Registrar's garlands		68. Registrar's garlands		69. Registrar's garlands	
70. Registrar's garlands		71. Registrar's garlands		72. Registrar's garlands	
73. Registrar's garlands		74. Registrar's garlands		75. Registrar's garlands	
76. Registrar's garlands		77. Registrar's garlands		78. Registrar's garlands	
79. Registrar's garlands		80. Registrar's garlands		81. Registrar's garlands	
82. Registrar's garlands		83. Registrar's garlands		84. Registrar's garlands	
85. Registrar's garlands		86. Registrar's garlands		87. Registrar's garlands	
88. Registrar's garlands		89. Registrar's garlands		90. Registrar's garlands	
91. Registrar's garlands		92. Registrar's garlands		93. Registrar's garlands	
94. Registrar's garlands		95. Registrar's garlands		96. Registrar's garlands	
97. Registrar's garlands		98. Registrar's garlands		99. Registrar's garlands	
100. Registrar's garlands		101. Registrar's garlands		102. Registrar's garlands	

BUREAU V. S.

JUN 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 6494 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

06422
230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Hgts.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Hgts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8725 - 63 Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Elmer E Clark First Middle Last				4. DATE OF DEATH June 11th. 1956. Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1879		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley Clark				14. MOTHER'S MAIDEN NAME Rosana Edwards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Clark(Son)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior septal infarct L.B.B.B. 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart & big artery disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5-22-56
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/22 , 1956, to 6/11 , 1956, that I last saw the deceased alive on 6/11 , 1956, and that death occurred at 4P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Hageage				ADDRESS (Street, city or town, state) DATE SIGNED 3717-38th Ave. Cottage City Md. 6-11-56			
PHYSICIAN'S NAME (Type) George J. Hageage				3717 38th. Ave. Cottage city Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Seis Sons Co.				ADDRESS 300 - 4th St. N. W. D.C.		24a. REC'D BY REGISTRAR John D. Smith	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6416
CERTIFICATE OF DEATH

06423

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOME</u> <u>5805 QUEENS CHAPEL ROAD</u>		d. STREET ADDRESS <u>1745 N. CASTLE ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>DOEBEL</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF-EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALOYSIUS DOEBEL</u>		14. MOTHER'S MAIDEN NAME <u>THERESIA Romcis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SACRED HEART HOME RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GASTRIC ULCER</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEKS</u> <u>3 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 6</u> , 19 <u>56</u> , to <u>JUNE 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JUNE 25</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Collins</u>		ADDRESS (Street, city or town, state) <u>324 H ST NE</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		<u>WASHINGTON D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>3821-14th ST. N.W. WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>June 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Jas. Severe</u>	

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06424

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pierce Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pierce Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchy 21 hrs 35 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Pierce Georges Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>WELDON</u> Last <u>Dunaway</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-15/55</u>
9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>5</u> Days <u>12</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant - None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL WELDON DUNAWAY SR.</u>		14. MOTHER'S MAIDEN NAME <u>EDNA HARRIET WHITELY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>CARL W DUNAWAY SR</u>		Address <u>14A Laurel Hill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO <u>Lung Abscess (Right Upper Lobe)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> (c) <u>24 hrs.</u> <u>24 hrs.</u> <u>78 hrs.?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/20</u> , 19 <u>56</u> to <u>6/27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6/27</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Roth</u>		ADDRESS (Street, city or town, state) <u>5510 Madison St. Riverdale, MD</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>		DATE SIGNED <u>6/27/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON VALE Cem</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co, Riverdale, MD</u>		24a. REC'D BY REGISTRAR <u>W. J. 1095</u>	
ADDRESS <u>Riverdale, MD</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. 1095</u>	

6441

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keywood Gardens</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>4806 Russell Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Everett</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-56</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>19</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Everett Robert Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Chesault, Jo Anne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother - as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (800 gms. 36 cm)</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. _____ p. m. _____ Month _____ Day _____ Year <u>1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>56</u> , to <u>6/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>56</u> , and that death occurred at <u>3:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>[Address]</u> DATE SIGNED <u>6-12-56</u>			
PHYSICIAN'S NAME (Type) <u>Aaron Dietz</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>Cremation</u>	<u>June 1956</u>	<u>Prince Georges Gen. Hosp. Cemetery Md.</u>		<u>Cherry Hill</u>		<u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>[Signature]</u>				<u>[Signature]</u>		<u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077182 XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 21, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		12. SIGNATURE OF CLERK <i>John Doe</i>	

RECEIVED
JUN 21 1956
BUREAU 1111

6417

CERTIFICATE OF DEATH

06427

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <i>Prince George's MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN lb <i>1 day</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		15-56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Land Branch Navy Hospital 849 Mont Hampton Ar</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harriet Isabel Everhart</i>		4. DATE OF DEATH Month <i>June</i> Day <i>11</i> Year <i>1956</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar 29 1865</i>	
9. AGE (In years (day) yrs.) <i>91</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>12</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Berryville Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John W. Carlisle</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Ward</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>C. L. Roy, Everhart</i>		Address <i>849 Mont Hampton Silver Spring Md</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mal-nutrition - Aritanmonis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Aritanmonis</i> DUE TO (c) <i>Acute Aritanmonis</i> <i>paranately but 3 mo.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/5/57</i> , 19 <i>57</i> , to <i>6/11/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/11/56</i> , 19 <i>56</i> , and that death occurred at <i>207</i> M., from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <i>Howard T. Morse</i>		ADDRESS (Street, city or town, state) <i>2630 Carroll Ave Takoma Park, Md</i>	
PHYSICIAN'S NAME (Type) <i>Howard T. Morse M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/13/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenhill Cemetery</i>		22d. LOCATION (City, town or county) (State) <i>Berryville Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Evell</i>		ADDRESS <i>Berryville</i>	
24a. REC'D BY REGISTRAR <i>6-13-1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe</i>	

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6442

CERTIFICATE OF DEATH

Reg. Dist. No. 66428
231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4504 Emerson St.</u>	
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Fowler</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1882</u>
9. AGE (In years (say birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>15</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Alfred H. Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah V. Bodensick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Maurine S. Fowler</u>		Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1953</u> , 19 <u>53</u> , to <u>12 Jun</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 Jun</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Kehoe</u>		ADDRESS (Street, city or town, state) <u>CHEVERLY, MD.</u>	
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>		DATE SIGNED <u>Cheverly, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Maduch</u>	

6443

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P.M.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hosp</u>		e. STREET ADDRESS <u>3906 Newton St</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Frank</u> Last <u>Frank</u>		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-00</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker Md state</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph a Frank</u>		14. MOTHER'S MAIDEN NAME <u>Fannie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>10</u>	
17. INFORMANT <u>Hospital Records Cherbury, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture left middle Meningeal Artery</u> <u>444X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>45</u> , to <u>June 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>56</u> , and that death occurred at <u>5:11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. C. Hageage</u>		M.D. <u>Mt. Rainier, Md.</u> DATE SIGNED <u>June 14, 1956</u>	
PHYSICIAN'S NAME (Type) <u>C. C. Hageage</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>6/16/56</u>	<u>Fort Lincoln</u>	<u>Colmar Manor Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Seck's sons Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u>Q. W. Huduck</u> 24b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE <u>JUN 18 1956</u>	

1
38
77
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

643

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14 1924		MOBILE, ALABAMA	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		MAY 1 1968		MEMPHIS, TENNESSEE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
ATTORNEY		SHOOTING		SUICIDE	
EDUCATION		SEX		RACE	
HIGH SCHOOL		MALE		WHITE	
RELIGION		TENDENCY		TEMPERATURE	
METHODIST		NONE		98.6	
HABIT		PULSE		BLOOD PRESSURE	
SMOKER		60		120/80	
DRINKER		WEIGHT		HEIGHT	
NONE		170		5' 10"	
SCARS		TATTOOS		FINGER MARKS	
NONE		NONE		NONE	
DISEASES		SYMPTOMS		TREATMENT	
NONE		NONE		NONE	
PREVIOUS DEATHS		LAST ILLNESS		LAST SEEN ALIVE	
NONE		NONE		MAY 1 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
NONE		NONE		NONE	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NONE		NONE		NONE	

BUREAU V. 2

MAY 18 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06430

2411 N. Charles Street, Baltimore

6495

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 404 6th St., N. W.	
3. NAME OF DECEASED (Type or Print)	(First) EMIL	(Middle)	(Last) FRANZEL
4. DATE OF DEATH	(Month) 6	(Day) 26	(Year) 1956
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7/17/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Ft. Belvoir	9. AGE last birthday 74 yrs. If under 1 year 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ferdinand Franzel		14. MOTHER'S MAIDEN NAME Theresa Phats	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Decedent

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
150X Immediate cause (a) Postoperative shock following esophagectomy 1 day		
Antecedent cause(s) (b) Carcinoma of the Esophagus 1 month		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Pulmonary Tuberculosis 5 yrs.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 6/26/56	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Esophagus	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/30, 1956, to 6/26, 1956, that I last saw the deceased alive on 6/26, 1956; and that death occurred at 5:35 P. m., from the causes and on the date stated above.

SIGNATURE Francis D. Costello ADDRESS Glenn Dale Md. DATE SIGNED 6/26/56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 6-29-56	NAME OF CEMETERY OR CREMATORY Rock Creek Wash. D.C.	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 6/26/56	REGISTRAR'S SIGNATURE Noel Weir	24. FUNERAL DIRECTOR	ADDRESS
		Nalley's Funeral Home 300 Rainer Rd	

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 5 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06431

6496

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>same</u> b. COUNTY <u>same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3715 Ocean</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES REMWICK GARLAND</u>		4. DATE OF DEATH <u>June 17 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Ta.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Florence Davis</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 422.1 DUE TO <u>Arterio-sclerotic cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic vascular</u> (c) <u>Arterio-sclerotic vascular</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour a. p. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>same</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 12, 1956</u> to <u>JUNE 17, 1956</u> , that I last saw the deceased alive on <u>JUNE 12, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u>		ADDRESS (Street, city or town, state) <u>4713 - Remond</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		DATE SIGNED <u>6/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 21, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Run Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mc Donald Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>DATE 6-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6444

CERTIFICATE OF DEATH

06432

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>6004 Rhode Island</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul TUTTLE</u> First Middle Last				4. DATE OF DEATH <u>June 10, 1956</u> Month Day Year			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/94</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector U.S. Govt</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Denver, Colorado</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence L. Gates</u>				14. MOTHER'S MAIDEN NAME <u>Lida Tuttle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>521-10-2094</u>		17. INFORMANT <u>Edith C. Gates Riverdale, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Rectum</u> DUE TO (c) <u>Myocardial Infarction</u> 2 months 1954-1 1/2 yr						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 9, 1956</u> , to <u>June 11, 1956</u> , that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W Kelley</u> M.D.				ADDRESS (Street, city or town, state) <u>Hyattsville, Md</u> DATE SIGNED <u>6/10/56</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Guske sons Hyattsville Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>6-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

File No. 100

1. NAME OF DECEASED MAYNARD		2. PLACE OF BIRTH Maryland	
3. SEX Male		4. AGE 21	
5. DATE OF DEATH June 13, 1956		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES (None)	
13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF CORONER (None)	
15. SIGNATURE OF REGISTRAR (None)		16. SIGNATURE OF CLERK (None)	

BUREAU V. 3

JUN 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06433

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 2407 Arundel Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle E Last Gibson			4. DATE OF DEATH Month June Day 7 Year 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1915		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander Cross			14. MOTHER'S MAIDEN NAME Eva Longridge				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT A. Cross		Address Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty degeneration of the liver DUE TO (c) Chronic ulcerative colitis							INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7, 1956 to May 7, 1956 , that I last saw the deceased alive on May 7, 1956 , and that death occurred at 11:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.				ADDRESS (Street, city or town, state) 4300 Kaywood Dr Mt Rainier Md			
PHYSICIAN'S NAME (Type)				DATE SIGNED 5/8/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/11/56		Mt. View		Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. [Signature]				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6-12-56	
				24b. REGISTRAR'S SIGNATURE A. N. Hedrick			

CERTIFICATE OF DEATH

Form 100-100

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF CHURCH [Faint text]</p>		<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>19. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>20. SIGNATURE OF CHURCH [Faint text]</p>	
<p>21. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>22. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>23. SIGNATURE OF INTERMENT [Faint text]</p>		<p>24. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>25. SIGNATURE OF CHURCH [Faint text]</p>		<p>26. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>27. SIGNATURE OF CEMETERY [Faint text]</p>		<p>28. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>29. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>30. SIGNATURE OF CHURCH [Faint text]</p>	
<p>31. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>32. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>33. SIGNATURE OF INTERMENT [Faint text]</p>		<p>34. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>35. SIGNATURE OF CHURCH [Faint text]</p>		<p>36. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>37. SIGNATURE OF CEMETERY [Faint text]</p>		<p>38. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>39. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>40. SIGNATURE OF CHURCH [Faint text]</p>	
<p>41. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>42. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>43. SIGNATURE OF INTERMENT [Faint text]</p>		<p>44. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>45. SIGNATURE OF CHURCH [Faint text]</p>		<p>46. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>47. SIGNATURE OF CEMETERY [Faint text]</p>		<p>48. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>49. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>50. SIGNATURE OF CHURCH [Faint text]</p>	
<p>51. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>52. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>53. SIGNATURE OF INTERMENT [Faint text]</p>		<p>54. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>55. SIGNATURE OF CHURCH [Faint text]</p>		<p>56. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>57. SIGNATURE OF CEMETERY [Faint text]</p>		<p>58. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>59. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>60. SIGNATURE OF CHURCH [Faint text]</p>	
<p>61. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>62. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>63. SIGNATURE OF INTERMENT [Faint text]</p>		<p>64. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>65. SIGNATURE OF CHURCH [Faint text]</p>		<p>66. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>67. SIGNATURE OF CEMETERY [Faint text]</p>		<p>68. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>69. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>70. SIGNATURE OF CHURCH [Faint text]</p>	
<p>71. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>72. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>73. SIGNATURE OF INTERMENT [Faint text]</p>		<p>74. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>75. SIGNATURE OF CHURCH [Faint text]</p>		<p>76. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>77. SIGNATURE OF CEMETERY [Faint text]</p>		<p>78. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>79. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>80. SIGNATURE OF CHURCH [Faint text]</p>	
<p>81. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>82. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>83. SIGNATURE OF INTERMENT [Faint text]</p>		<p>84. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>85. SIGNATURE OF CHURCH [Faint text]</p>		<p>86. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>87. SIGNATURE OF CEMETERY [Faint text]</p>		<p>88. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>89. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>90. SIGNATURE OF CHURCH [Faint text]</p>	
<p>91. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>92. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>93. SIGNATURE OF INTERMENT [Faint text]</p>		<p>94. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>95. SIGNATURE OF CHURCH [Faint text]</p>		<p>96. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>97. SIGNATURE OF CEMETERY [Faint text]</p>		<p>98. SIGNATURE OF INTERMENT [Faint text]</p>	
<p>99. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>		<p>100. SIGNATURE OF CHURCH [Faint text]</p>	

BUREAU V. 1

JUN 12 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6418

Item 2, FilmG 00 7-24-56 et

CERTIFICATE OF DEATH

06434

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington Prince George 21	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Hagerstown 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5805 Queens Chapel Road Sacred Heart Home		d. STREET ADDRESS 1016 Oak Hill Ave. 5805/Queens/Chapel/Road/ 2	
3. NAME OF DECEASED (Type or print) AGNES G. GILBERT		4. DATE OF DEATH June 20, 1956 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1867
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 19 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wendslin Gilbert		14. MOTHER'S MAIDEN NAME Eva Hirsch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Address Sacred Heart Home Records-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1955, to June 19, 1956, that I last saw the deceased alive on June 19, 1956, and that death occurred at 7:10AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6-21-56 DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Collins M.D.		322 H Street, NE	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M. D.		Washington 2, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-56	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Carrol Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md	
24a. REC'D BY REGISTRAR DATE June 23 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy	

CERTIFICATE OF DEATH

6418

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
SALES MAN		HIGH SCHOOL		MARRIED		JULY 1950		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		SUICIDE		JAN 19 1964		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAN 19 1964		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
FILING DATE		FILING PLACE		FILING CITY		FILING STATE		FILING COUNTRY		FILING CITY		FILING STATE		FILING COUNTRY	
JAN 20 1964		BALTIMORE		MARYLAND		UNITED STATES		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	

BUREAU V. M.

JAN 20 1964

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6425

CERTIFICATE OF DEATH

06435

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6707 Conway Ave				d. STREET ADDRESS 6706 Conway Ave			
3. NAME OF DECEASED (Type or print) Mildred First Pauline Middle Graeff Last				4. DATE OF DEATH June 14 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 6 1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Henry Long				14. MOTHER'S MAIDEN NAME Stella Edna Stieglitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 183-05-7155		17. INFORMANT Charles Graeff 6706 Conway, Takoma Park, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Unclassified Malignant Neoplasm of it DUE TO Kidney & surrounding area, + Conditions, if any, which gave rise to immediate cause (b) metastasis DUE TO Liver Sec Anemia - IMMEDIATE CAUSE (c) since				INTERVAL BETWEEN ONSET AND DEATH Found on 6/5/56			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/18/1944, to 6/14/1956, that I last saw the deceased alive on 6/14/1956, and that death occurred at 11:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard T. Morse				ADDRESS (Street, city or town, state) 7030 Carroll Ave. Takoma Park, Md			
PHYSICIAN'S NAME (Type) Howard T. Morse M.D.				DATE SIGNED 6/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Greenwood cem.		22d. LOCATION (City, town, or county) (State) Porter Twp., Sch Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Patton				ADDRESS 254 Carroll St NW		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film GL 99 6-22-56 et

06436

CERTIFICATE OF DEATH

Reg. Dist. No. 231

6446

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Henry Griffin				4. DATE OF DEATH Month Day Year June 14 1956			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-9260A		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia secondary to bilateral hydronephrosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) Carcinoma of the Prostate Gland						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dayton O. Watkins M.D.				ADDRESS (Street, city or town, state) 5304 Annapolis Rd			
PHYSICIAN'S NAME (Type) DAYTON O. WATKINS				DATE SIGNED Bladensburg, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-22-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town or county) (State) Fort Meade, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier Funeral Home				ADDRESS 389 R.I. ave. N.W.		24a. REC'D BY REGISTRAR 6-21-56	
						24b. REGISTRAR'S SIGNATURE A.W. Hedrick	

BUREAU V. 5

Page 4: TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG200 7-21-56 et

06437

6497
CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17012 - Montgomery Rd.</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA - F Middle Griffith last</u>		4. DATE OF DEATH <u>June 27 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13, 1899</u>
9. AGE (In years last birthday) <u>57</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Trout Greble</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bradley French</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Llewellyn B. Griffith</u>		Address <u>Arlington Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days 10 - yrst</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>51</u> , to <u>June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JUNE 27</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u>		ADDRESS (Street, city or town, state) <u>4712 - Montgomery Rd College Park, Md.</u>	
DATE SIGNED <u>6/27/56</u>			
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Fr., Geo. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. GASCH'S SONS</u>		ADDRESS <u>Hyattsville, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

6498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	c. LENGTH OF STAY IN 1b 16 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 5		d. STREET ADDRESS Route # 5	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Thelma Agnes Grimsley		4. DATE OF DEATH Month Day Year June 5 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eben Williamson	
14. MOTHER'S MAIDEN NAME Emma Fairfax		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Elizabeth Majors	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cnigestive heart failure 442X DUE TO Arterial heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED June 5, 1956	

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 7-56	22b. DATE THEREOF June 7-56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros 1661-gd Hope Rd SE		24a. REC'D BY REGISTRAR June 5-56	24b. REGISTRAR'S SIGNATURE Edna F. Sills

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2.

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6447 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>35 mile</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>5805 Maryhurst</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Frederick Hildebrand</u>				4. DATE OF DEATH <u>June 9 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17, 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Used cars</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Hildebrand</u>				14. MOTHER'S MAIDEN NAME <u>Bertha May Nangle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Agnese Hildebrand, same as #2</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MANOR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. - RIVERDALE, MD.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

JUN 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06440

6448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges'</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges'</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. LENGTH OF STAY IN 1b <i>35 1/2 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges' General Hospital</i>		d. STREET ADDRESS <i>4110 - 53rd Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Ide</i> Middle <i>LOUISE</i> Last <i>Hilliard</i>		4. DATE OF DEATH Month <i>6</i> Day <i>25</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-16-1876</i>
9. AGE (In years lost birthday) <i>80 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William George Harrison</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA CORNWALL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Statistic Card</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>e. v. a</i> <i>442</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO (c) <i>Stroke</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-23-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-23</i> , 1956, to <i>6-25</i> , 1956, that I last saw the deceased alive on <i>6/25</i> , 1956, and that death occurred at <i>6:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Haggage</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>3717-38th Ave. Coxsack, N.Y. 6/26/56</i>	
PHYSICIAN'S NAME (Type) <i>George J. Haggage</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/25/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT HOPE CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ROCHESTER, N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chamber C.</i>		ADDRESS <i>5801 Chandler Ave. Thuidale Md.</i>	
24a. REC'D BY REGISTRAR <i>W. W. Chamber C.</i>		24b. REGISTRAR'S SIGNATURE <i>W. W. Chamber C.</i>	

BUREAU V. 2

UN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

6412

CERTIFICATE OF DEATH

Reg. Dist. No. 130

06441

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5014 Hollywood, Rd.		d. STREET ADDRESS 602 Harding Place	
3. NAME OF DECEASED (Type or print) GEORGE WASHINGTON HOFMASTER		4. DATE OF DEATH June 5, 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1893, 6378 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Superintendent Millwork		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Marcia castella, College Park Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/11, 1956, to 6/5, 1956, that I last saw the deceased alive on 6/4, 1956, and that death occurred at 3:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Louis Mendel		M.D. 4506 COLLEGE AVE.	
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL		COLLEGE PARK, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8, 1956	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Ritchie Highway (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 6/7/56	
		24b. REGISTRAR'S SIGNATURE John D. Smith	

6419

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George</i> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>15 Seatonsville</i>	STATE <i>Prince George Maryland</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Maryland Park Md</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Paint Branch Nursing Home</i>		STREET ADDRESS (If rural give location) <i>6411 Central Ave</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>LOUISA F HOHMAN</i>		<i>June 30 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>Aug. 12-1872</i>
9. AGE last birthday <i>83</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	11. BIRTHPLACE (State or foreign country): <i>Germany</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME: <i>Fredrick Koch</i>	
14. MOTHER'S MAIDEN NAME: <i>Unknown</i>		15. INFORMANT & ADDRESS: <i>John C. Hohman 713-Shoalside Sides Spring</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		17. SOCIAL SECURITY NO. <i>No</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>			<i>7-10 days</i>
ANTECEDENT CAUSE (S) DUE TO <i>Arteriosclerosis</i>			<i>2y</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Semlitz</i>			<i>"</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>5</i>		19B. MAJOR FINDINGS OF OPERATION <i>0</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>50 6/30/56</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>July 1956</i> , to <i>6/30/56</i> , that I last saw the deceased alive on <i>6/29/56</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>W. N. Wolohin</i>		M. D. <i>500 Underwood St</i> DATE SIGNED <i>June 6/30/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 30 1956</i>		REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severance</i>	
24. FUNERAL DIRECTOR <i>John Lee & Sons</i>		ADDRESS <i>Shash. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66443

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1107 Addison Road				d. STREET ADDRESS 1105 Addison Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Luke Hays Jackson				4. DATE OF DEATH Month Day Year June 27 19 56				
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-19-09		
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY Tonsorial		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jackson				14. MOTHER'S MAIDEN NAME Sarah Eichelberger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 231-46-9312		17. INFORMANT James Miles, 1124 Oates St. N.E., D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 983X DUE TO Fracture of vault of skull Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 							INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured in altercation with another man.					
20c. TIME OF INJURY Month, Day, Year 3.00 6-27 19 56			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard		20f. (City or town) (County) (State) Fairmount Hts-Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 28, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, lawn, or county) (State) Md-Suitland		
23. FUNERAL DIRECTOR'S SIGNATURE M. K. Halling				ADDRESS 4337 Mount Pleasant		24a. REC'D BY REGISTRAR DATE 7-1-56		
				24b. REGISTRAR'S SIGNATURE Carrie Campbell				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6449

CERTIFICATE OF DEATH

06444

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Ind.</u>				c. LENGTH OF STAY IN 1b <u>12 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meade Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>1811 Patton Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Johnson Arthur</u>				14. MOTHER'S MAIDEN NAME <u>Rock Evelyn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother's as above</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-8</u> , 19 <u>56</u> , to <u>30-6-8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-8</u> , 19 <u>56</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5501 Hamilton St., Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				DATE SIGNED <u>Jul 9/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges St. Mary Church</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Perkins</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JUN 21 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. W. W.</u>	

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BUREAU A. 1.

JUN 21 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6450

CERTIFICATE OF DEATH

06445

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General Hospital</i>				d. STREET ADDRESS <i>3011 Sheridan Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>Aggell</i> Last <i>Johnson</i>				4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-13-1882</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maine</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>FRANK GILMAN</i>			
14. MOTHER'S MAIDEN NAME <i>CATHERINE WEYMOUTH</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) <i>NONE</i>			
16. SOCIAL SECURITY NO. <i>NONE</i>				17. INFORMANT <i>ANNIE B. STEWARTS-5011 SHERIDAN ST</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pulmonary edema and congestion</i> DUE TO (c) <i>Cerebral thrombosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH</i> (b) <i>48 hrs.</i> (c) <i>24 hrs.</i> (d) <i>5 years.</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. <i>m.</i> <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>6-1</i> , 19 <i>56</i> , to <i>6-6</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6-6</i> , 19 <i>56</i> , and that death occurred at <i>9:05 A.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Gordon W. Kelley</i>				M.D. <i>Hyatt, Md</i> <i>6/6/56</i>			
PHYSICIAN'S NAME (Type) <i>Gordon W. Kelley</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/8/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATL CO - ARLINGTON, VA.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS - RIVERDALE MD</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>J. H. Hedrick</i>	
24b. REGISTRAR'S SIGNATURE				DATE <i>JUN 8 1956</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

064462x

Reg. Dist. No. 240

6520

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cheltenham		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In a wooded area				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Thomas Middle Melvin Last Johnson				4. DATE OF DEATH Month June Day 12 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 11, 1929		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 26	IF UNDER 24 HRS. Hours 26 Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lawrence Johnson				14. MOTHER'S MAIDEN NAME Julia Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 220266523		17. INFORMANT William Hall, La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed skull (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head was crushed by a falling tree					
20c. TIME OF INJURY Month, Day, Year 4:30 p. m. June 12 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) Cheltenham P. G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 15, 1956		22c. NAME OF CEMETERY OR CREMATORY St Mary's Com.	
				22d. LOCATION (City, town, or county) (State) Newport Md.			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 6-18-56	
				24b. REGISTRAR'S SIGNATURE John E. Danner			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 81 N11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

CERTIFICATE OF DEATH

Reg. Dist. No. 6447

1. PLACE OF DEATH o. COUNTY Pr. Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo. Gen. Hosp.		d. STREET ADDRESS 6610 Patterson Street	
3. NAME OF DECEASED (Type or print) First Alice Middle Rose Last Kayser		4. DATE OF DEATH Month June Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Aug. 1894
9. AGE (In years (last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Carney		14. MOTHER'S MAIDEN NAME Mary F. Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Marilyn Kayser		Address Same add., as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Insufficiency (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Last. 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan., 1950 to June, 1956 , that I last saw the deceased alive on June 27, 1956 , and that death occurred at 9 A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller M.D.		ADDRESS (Street, city or town, state) 3824-34th St. Baltimore, Md.	
DATE SIGNED July 28			
PHYSICIAN'S NAME (Type) Benjamin S. Miller			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Pr. Geo., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR JUL 6 1956		24b. REGISTRAR'S SIGNATURE J. W. Anderson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
Item 2, Film G199 6-27-56 et
6452
CERTIFICATE OF DEATH

06448

Reg. Dist. No. 242

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACORDA REST HOME		d. STREET ADDRESS 2601 CHEVERLY AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle BELL Last KEMP		4. DATE OF DEATH Month JUNE Day 16 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WH.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1871
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESS MAKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LURAY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DANIEL KEMP		14. MOTHER'S MAIDEN NAME MARY SUSAN CULLERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 443X DUE TO HYPERTENSIVE CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH FEB. 56-JUNE 16	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. 15, 1956 , to JUNE 16, 1956 , that I last saw the deceased alive on JUNE 14, 1956 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max M. Herzberg		ADDRESS (Street, city or town, state) 7016 GRIG ST, SEAT Pleasant, MD.	
PHYSICIAN'S NAME (Type) MAX M. HERZBERG, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 19 1956	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Sedon Hill	22d. LOCATION (City, town, or county) (State) Smithland Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. William Lee's Sons Co		24a. REC'D BY REGISTRAR DATE 6-20-56	
ADDRESS 300-4th St		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 245

06449

Item 6501 2-15-57-6
210210

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5014 Edmonston Rd		d. STREET ADDRESS 5014 Edmonston Rd	
3. NAME OF DECEASED (Type or print) First HINRICH Middle KLEEBERG Last		4. DATE OF DEATH June 17, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 9, 1881
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral Thrombosis (b) arteriosclerotic cardiovasc. dis (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis of femoral artery			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-24-55 to 6-17-56, that I last saw the deceased alive on 6-17-56, and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard Gitter		DATE SIGNED 6-17-56	
PHYSICIAN'S NAME (Type) RICHARD GITTER M.D.		ADDRESS (Street, city or town, state) 656 East Cap. Hk., Wash. 3, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 20, 1956	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	
DATE June 19, 1956		Deputy	

page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6591

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER	
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43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

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JUN 20 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6453 CERTIFICATE OF DEATH

Reg. Dist. No. 231

06450

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>			e. STREET ADDRESS <u>4117 Cottage City Terrace</u>		
3. NAME OF DECEASED (Type or print) <u>Baby Boy Lamoreaux</u>			4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1954</u>		9. AGE (In years last birthday) yrs. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Lamoreaux, Thomas</u>			14. MOTHER'S MAIDEN NAME <u>M^{rs} Williams, Betty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Focal atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>June 8, 1956</u> , to <u>June 10, 1956</u> , that I last saw the deceased alive on <u>June 10, 1956</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. L. Etienne</u>		M.D. <u>College Park</u>		DATE SIGNED <u>6-11-56</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>					

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nolley Funeral Home</u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	24b. REGISTRAR'S SIGNATURE <u>A. W. March</u>

20770333XV2

CERTIFICATE OF DEATH

0053

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION	
MILITARY SERVICE		DATE OF MILITARY SERVICE		PLACE OF MILITARY SERVICE	
PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH	
SIGNATURE OF DECEASED		DATE OF SIGNATURE OF DECEASED		PLACE OF SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		DATE OF SIGNATURE OF WITNESS		PLACE OF SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE OF PHYSICIAN		PLACE OF SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		DATE OF SIGNATURE OF CORONER		PLACE OF SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		DATE OF SIGNATURE OF JUDGE		PLACE OF SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		DATE OF SIGNATURE OF CLERK		PLACE OF SIGNATURE OF CLERK	

BUREAU V. 1

JUN 13 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G199 6-28-56 et

6454

CERTIFICATE OF DEATH

06451

Reg. Dist. No. 239

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George		MARYLAND		STATE Md.		COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Laurel		LENGTH OF STAY (in this place) 20yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Laurel,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 431 Main St.,			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Jerome Lappielle				4. DATE OF DEATH (Month) (Day) (Year) June 15, 1956 19			
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 22, 1888	9. AGE last birthday 68 67yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Regina (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 220-03-1083		17. INFORMANT & ADDRESS 7 Meriden Place Mrs. Regina Copeland Long Island			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 584X Acute Coronary Dilatation				INTERVAL BETWEEN ONSET AND DEATH 3 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Emphysema - Asthma							
DUE TO (C) Overriding: Coronary Cardiovascular dis. Phlebotomy							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 6/12/56		19b. MAJOR FINDINGS OF OPERATION Gall Stones		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1956, to 6/15, 1956, that I last saw the deceased alive on 6/15, 1956, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
SIGNATURE J. B. Warren		M.D.		ADDRESS (Street, city, town, state) Laurel Md		DATE SIGNED 6/15/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF June 18, 1956		NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		LOCATION (City, town, or county) (State) Dorsey, Md.	
24. REC'D BY REGISTRAR June 20-56		REGISTRAR'S SIGNATURE M. B. Grashere		25. FUNERAL DIRECTOR'S SIGNATURE H. H. Ronaldson		ADDRESS Laurel Md	

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Occupation (If any)

7. Cause of death (If known)

8. Date of death (Month, Day, Year)

9. Time of death (Hour, Minute)

10. Place of death (City, State, Country)

11. Signature of attending physician

12. Signature of registrar

13. Signature of medical examiner

14. Signature of coroner

15. Signature of funeral director

16. Signature of informant

17. Signature of registrar

18. Signature of medical examiner

19. Signature of coroner

20. Signature of funeral director

BUREAU V. 1

JUN 25 1956

RECEIVED

2407018781

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A PASSPORT ONLY. IT DOES NOT CONSTITUTE A GUARANTEE OF THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE INFORMATION CONTAINED HEREIN IS FOR OFFICIAL USE ONLY. IT IS NOT TO BE RELEASED TO THE PUBLIC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9, Film 198 6-18-56 et

06452

6455

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gilford</u>	
c. LENGTH OF STAY IN 1b <u>14 hours</u>		d. STREET ADDRESS <u>13 x - 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>EMORY</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE W LEE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Statistic Card</u>	
17. INFORMANT <u>Statistic Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. Arteriosclerosis</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Gastroenteritis acute</u> DUE TO <u>Severe Dehydration & Malnutrition</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-6</u> , 19 <u>56</u> to <u>6-7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6-7</u> , 19 <u>56</u> , and that death occurred at <u>9364</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. Sugar</u> M.D.		ADDRESS (Street, city or town, state) <u>Mr. Ranner, Md</u> DATE SIGNED <u>6/7/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higginbotham</u> ADDRESS <u>Ellicott City</u>		24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u> 24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	

RECEIVED
JAN 11 1956
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1. NAME OF DECEASED <i>George W. Lee</i>		2. SEX <i>Male</i>		3. AGE <i>68</i>	
4. DATE OF DEATH <i>Jan 10 1956</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. PLACE OF BIRTH <i>Washington, D.C.</i>		8. OCCUPATION <i>Retired</i>		9. MARITAL STATUS <i>Married</i>	
10. DATE OF BIRTH <i>Jan 10 1888</i>		11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. DATE OF DEATH <i>Jan 10 1956</i>		14. PLACE OF DEATH <i>Home</i>		15. CAUSE OF DEATH <i>Heart Disease</i>	
16. DATE OF DEATH <i>Jan 10 1956</i>		17. PLACE OF DEATH <i>Home</i>		18. CAUSE OF DEATH <i>Heart Disease</i>	
19. DATE OF DEATH <i>Jan 10 1956</i>		20. PLACE OF DEATH <i>Home</i>		21. CAUSE OF DEATH <i>Heart Disease</i>	
22. DATE OF DEATH <i>Jan 10 1956</i>		23. PLACE OF DEATH <i>Home</i>		24. CAUSE OF DEATH <i>Heart Disease</i>	
25. DATE OF DEATH <i>Jan 10 1956</i>		26. PLACE OF DEATH <i>Home</i>		27. CAUSE OF DEATH <i>Heart Disease</i>	
28. DATE OF DEATH <i>Jan 10 1956</i>		29. PLACE OF DEATH <i>Home</i>		30. CAUSE OF DEATH <i>Heart Disease</i>	
31. DATE OF DEATH <i>Jan 10 1956</i>		32. PLACE OF DEATH <i>Home</i>		33. CAUSE OF DEATH <i>Heart Disease</i>	
34. DATE OF DEATH <i>Jan 10 1956</i>		35. PLACE OF DEATH <i>Home</i>		36. CAUSE OF DEATH <i>Heart Disease</i>	
37. DATE OF DEATH <i>Jan 10 1956</i>		38. PLACE OF DEATH <i>Home</i>		39. CAUSE OF DEATH <i>Heart Disease</i>	
40. DATE OF DEATH <i>Jan 10 1956</i>		41. PLACE OF DEATH <i>Home</i>		42. CAUSE OF DEATH <i>Heart Disease</i>	
43. DATE OF DEATH <i>Jan 10 1956</i>		44. PLACE OF DEATH <i>Home</i>		45. CAUSE OF DEATH <i>Heart Disease</i>	
46. DATE OF DEATH <i>Jan 10 1956</i>		47. PLACE OF DEATH <i>Home</i>		48. CAUSE OF DEATH <i>Heart Disease</i>	
49. DATE OF DEATH <i>Jan 10 1956</i>		50. PLACE OF DEATH <i>Home</i>		51. CAUSE OF DEATH <i>Heart Disease</i>	
52. DATE OF DEATH <i>Jan 10 1956</i>		53. PLACE OF DEATH <i>Home</i>		54. CAUSE OF DEATH <i>Heart Disease</i>	
55. DATE OF DEATH <i>Jan 10 1956</i>		56. PLACE OF DEATH <i>Home</i>		57. CAUSE OF DEATH <i>Heart Disease</i>	
58. DATE OF DEATH <i>Jan 10 1956</i>		59. PLACE OF DEATH <i>Home</i>		60. CAUSE OF DEATH <i>Heart Disease</i>	
61. DATE OF DEATH <i>Jan 10 1956</i>		62. PLACE OF DEATH <i>Home</i>		63. CAUSE OF DEATH <i>Heart Disease</i>	
64. DATE OF DEATH <i>Jan 10 1956</i>		65. PLACE OF DEATH <i>Home</i>		66. CAUSE OF DEATH <i>Heart Disease</i>	
67. DATE OF DEATH <i>Jan 10 1956</i>		68. PLACE OF DEATH <i>Home</i>		69. CAUSE OF DEATH <i>Heart Disease</i>	
70. DATE OF DEATH <i>Jan 10 1956</i>		71. PLACE OF DEATH <i>Home</i>		72. CAUSE OF DEATH <i>Heart Disease</i>	
73. DATE OF DEATH <i>Jan 10 1956</i>		74. PLACE OF DEATH <i>Home</i>		75. CAUSE OF DEATH <i>Heart Disease</i>	
76. DATE OF DEATH <i>Jan 10 1956</i>		77. PLACE OF DEATH <i>Home</i>		78. CAUSE OF DEATH <i>Heart Disease</i>	
79. DATE OF DEATH <i>Jan 10 1956</i>		80. PLACE OF DEATH <i>Home</i>		81. CAUSE OF DEATH <i>Heart Disease</i>	
82. DATE OF DEATH <i>Jan 10 1956</i>		83. PLACE OF DEATH <i>Home</i>		84. CAUSE OF DEATH <i>Heart Disease</i>	
85. DATE OF DEATH <i>Jan 10 1956</i>		86. PLACE OF DEATH <i>Home</i>		87. CAUSE OF DEATH <i>Heart Disease</i>	
88. DATE OF DEATH <i>Jan 10 1956</i>		89. PLACE OF DEATH <i>Home</i>		90. CAUSE OF DEATH <i>Heart Disease</i>	
91. DATE OF DEATH <i>Jan 10 1956</i>		92. PLACE OF DEATH <i>Home</i>		93. CAUSE OF DEATH <i>Heart Disease</i>	
94. DATE OF DEATH <i>Jan 10 1956</i>		95. PLACE OF DEATH <i>Home</i>		96. CAUSE OF DEATH <i>Heart Disease</i>	
97. DATE OF DEATH <i>Jan 10 1956</i>		98. PLACE OF DEATH <i>Home</i>		99. CAUSE OF DEATH <i>Heart Disease</i>	
100. DATE OF DEATH <i>Jan 10 1956</i>		101. PLACE OF DEATH <i>Home</i>		102. CAUSE OF DEATH <i>Heart Disease</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

06453

2411 N. Charles Street, Baltimore

6456

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 611 H. St., N. W.	
3. NAME OF DECEASED (Type or Print)	(First) Yock	(Middle)	(Last) Lee
5. SEX Male	6. COLOR OR RACE Chinese	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2/5/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker		10b. KIND OF BUSINESS OR INDUSTRY Laundry	9. AGE last birthday 60 yrs.
11. BIRTHPLACE (State or foreign country) Canton China		12. CITIZEN OF WHAT COUNTRY? China	
13. FATHER'S NAME - Tung Lou Lee		14. MOTHER'S MAIDEN NAME - Wong Shed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Pulmonary Hemorrhage			1 day
Antecedent cause(s) Pulmonary Tuberculosis			10 1/2 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Diabetes Mellitus			2 1/2 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/12/55, to 6/8/56, that I last saw the deceased

alive on 6/7/56, and that death occurred at 3:20 A.M., from the causes and on the date stated above.
 SIGNATURE Francis DeWate M. D. ADDRESS Glenn Dale Hospital DATE SIGNED 6/8/56
 Glenn Dale, Maryland

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE 6-10-56	NAME OF CEMETERY OR CREMATORY Leedsington Memorial	LOCATION (City, town, or county) Prince Georges Co.	(State) Md.
DATE REC'D BY LOCAL REG. 6/8/56	REGISTRAR'S SIGNATURE W. W. W.	24. FUNERAL DIRECTOR John Lee 300-44125, 7040 DE		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 18 1956

RECEIVED

6457

CERTIFICATE OF DEATH

06454

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hosp				d. STREET ADDRESS 6420 Knollbrook Dr.			
3. NAME OF DECEASED (Type or print) Emma First Middle Last Leitner				4. DATE OF DEATH Month 6 - Day 11 - Year 1956			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/01	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver - Retired Textile				10b. KIND OF BUSINESS OR INDUSTRY Hazelton, Pa.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Dominick Tait				14. MOTHER'S MAIDEN NAME Barbara (Tait) Rossi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 171-01-9849		17. INFORMANT Marie Parrell address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Carcinoma of the Breast with metastases to lung & spine DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1956, to June 11, 1956, that I last saw the deceased alive on June 10, 1956, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald Fleischer M.D.				ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd Hyattsville			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				DATE SIGNED 6-11-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-56		22c. NAME OF CEMETERY OR CREMATORY Our Lady of Mt. Carmel		22d. LOCATION (City, town, or county) (State) Hazelton, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS 3200 R.R. Ave. Mt Rainier, Md.		24a. REC'D BY REGISTRAR DATE 6-13-56	
				24b. REGISTRAR'S SIGNATURE A. W. Branch			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1956

RECEIVED

6413

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7208 Bowdoin Avenue,.</u>				d. STREET ADDRESS <u>7208 Bowdoin Avenue,.</u>			
3. NAME OF DECEASED (Type or print) <u>Emily Brinkley Lepson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13, 1878</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ernest H. Brinkley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Straugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Franklin P. Lepson College Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Carcinoma of Bladder</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9/17</u> , 19 <u>52</u> , to <u>6/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>56</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Louis Mendel</u> M.D.		ADDRESS (Street, city or town, state) <u>1506 COLLEGE AVE</u>		DATE SIGNED <u>6/16/56</u>			
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>		<u>COLLEGE PARK Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Beltsville, Maryland.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>	24b. REGISTRAR'S SIGNATURE <u>John W. Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN 19 1956

RECEIVED

6458

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's Gov. Hosp.</i>		d. STREET ADDRESS <i>219 Telegraph Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy Libby</i>		4. DATE OF DEATH <i>June 10, 1956</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 19, 1956</i>
9. AGE (In years last birthday) <i>11 B. yrs.</i>		IF UNDER 1 YEAR: Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min. <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Libby, Howard</i>		14. MOTHER'S MAIDEN NAME <i>Semke, Ruby</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>mother - as above</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Neonatal asphyxia</i> DUE TO <i>761.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Abortion complete</i> DUE TO <i>Premature separation of placenta</i> (c) <i>Premature separation of placenta</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/10</i> , 19 <i>56</i> , to <i>6/10</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/10</i> , 19 <i>56</i> , and that death occurred at <i>9:15</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Julius Kaufman</i>		ADDRESS (Street, city or town, state) <i>5102 Annap. Rd. Bladensburg, Md.</i>	
DATE SIGNED <i>6/10/56</i>			
PHYSICIAN'S NAME (Type) <i>Julius Kaufman</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>June 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Prince George's</i>		22d. LOCATION (City, town, or county) (State) <i>Chesley, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barry M. Penn</i>		ADDRESS <i>Adm</i>	
24a. REC'D BY REGISTRAR <i>307</i>		24b. REGISTRAR'S SIGNATURE <i>307</i>	
DATE <i>6/11/56</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

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 JUN 21 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 18, Film G200, Items 22, 23 Film G199 6-27-56 at 7-13-56 6592 CERTIFICATE OF DEATH 06457 Reg. Dist. No. 244									
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville			c. LENGTH OF STAY IN lb 2 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville				X
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1401st USAF Hospital, Andrews AFB, Md.					d. STREET ADDRESS Rosaryville Manor Apt #2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Patricia First Ann Middle Lisk Last					4. DATE OF DEATH June Month 19 Day 56 Year				
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1956		9. AGE (In years last birthday) 2 mos yrs.	IF UNDER 1 YEAR Months 1 Days 27	IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA			10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George P. Lisk					14. MOTHER'S MAIDEN NAME Catherine E. Stetser				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George P. Lisk, Rosaryville Manor, Rosaryville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined / - pending autopsy 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Pneumonitis, interstitial, bilateral DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient was premature baby, 2mos of age at time of death acute enterocolitis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA, 19 June, 19 56 , delivered from delivered from 1030 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE John W. Winkler Jr. M.D.					ADDRESS (Street, city or town, state) 1401st USAF Hospital, Andrews		DATE SIGNED 19 Jun 56		
PHYSICIAN'S NAME (Type) JOHN W. WINKLER, JR. USAF (MC) Capt					Air Force Base, Washington 25, D. C.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal			22b. DATE THEREOF --		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Runnemead, N. J.		
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		24a. REC'D BY REGISTRAR DATE 19 June 56		24b. REGISTRAR'S SIGNATURE Helen M. Michael

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6459 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66458
231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY Queens Co. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Lynch Last Lynch		4. DATE OF DEATH Month June Day 1 Year 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 22, 1913
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter Jennings		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Ruth Wyley		107-02 Union Hall St Jamaica N. Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, Fracture of left humerus, compound fracture of the left tibia and fibula and right patella, fracture of base of skull DUE TO (c) and right patella, fracture of base of skull PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of with another auto) Occupant of an automobile that was in a collision	
20c. TIME OF INJURY Month, Day, Year Hour 1:25 a. m. June 19 56		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) (County) (State) Cheltenham P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF June 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Crowe Funeral Home		22d. LOCATION (City, town, or county) (State) Jamaica New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR JUN 4 1956	
		24b. REGISTRAR'S SIGNATURE H. H. Shuck	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		PREVIOUS ILLNESS		HABITS		DIET		OTHER	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF CORONER		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF JURY		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF CLERK		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF JURY		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF CLERK		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		INITIALS	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		INITIALS	

BUREAU V. 8

JUN 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6420
CERTIFICATE OF DEATH

06459

Reg. Dist. No. **245**

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville,</u>			c. LENGTH OF STAY IN 1b <u>2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg Md.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Rest Home</u>				d. STREET ADDRESS <u>4104 53rd avenue,.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Martha Beatrice Lyons</u>			First Middle Last	4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1956</u>		19 <u>56</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Brink</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pertrosky</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Lional G. Lyons Bladensburg, Maryland.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm of aorta</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>June 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Perry St. MT Rainier Md</u>				
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>				DATE SIGNED <u>6/18/56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Staples, Todd Co., Minnesota</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Gasch's Sons</u> <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>June 19 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> <u>Deputy</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL ATTENDANT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF MEDICAL ATTENDANT [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

JUN 20 1956

RECEIVED

6421

CERTIFICATE OF DEATH

Reg. Dist. No. 245...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1913 Fox Street.</u>				STREET ADDRESS (If rural give location) <u>1913 Fox St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Alexander MacCollum</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 13 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 2, 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Book binder</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Printing</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Alexander MacCollum</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Cherry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>YES</u> ✓		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Maida MacCollum 1913 Fox St Hyattsville, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						<u>6 hours.</u>	
ANTECEDENT CAUSE (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cirrhosis of the Liver</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jun. 13, 1956</u> , to <u>Jun. 13, 1956</u> that I last saw the deceased alive on <u>June 13, 1956</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James L. Lambach</u>		ADDRESS <u>M.D. 1806 Fox St. Hyattsville, Md.</u>		DATE SIGNED <u>6/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON CO. VA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 14 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe (Deputy)</u>		24. FUNERAL DIRECTOR <u>W. H. Smith Co.</u>		ADDRESS <u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06461

6460

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400-38 th street		d. STREET ADDRESS 4400-38 th street	
3. NAME OF DECEASED (Type or print) Wesley E. Maye		4. DATE OF DEATH 6-21-1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27, 1906 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Nat. Security agent	
11. BIRTHPLACE (State or foreign country) Davisboro, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward E. Maye		14. MOTHER'S MAIDEN NAME Annie Brantley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X Uremia DUE TO (b) Left Uretal Obstruction DUE TO (c) Sarcoma of Urinary Bladder - Metastatic		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1956, to June 21, 1956, that I last saw the deceased alive on June 21, 1956, and that death occurred at 3:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1122 Decatur St NE, Atlanta, Ga. DATE SIGNED 6-21-56 ACTUAL SIGNATURE Richard L. Whelton M.D. PHYSICIAN'S NAME (Type) Richard L. Whelton MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Colmar Manor, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		24a. REC'D BY REGISTRAR DATE June 24, 1956 Mrs. Jas. Severe	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06462

6523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 357- Good Luck Road		d. STREET ADDRESS Box 357- Good Luck Road	
3. NAME OF DECEASED (Type or print) First Claude Middle McBride Last		4. DATE OF DEATH Month June Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1912
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Marie Mc Bride		Address Lanham, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted while charging wire enclosure of kennel.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6- p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lanham, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 21, 1956	
22a. REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56	
22c. NAME OF CEMETERY OR INTERMENT Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR JUN 27 1956		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 2 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

1956 27 JUN

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06463

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Pr. Geo. Co. MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Temple Hills Park TOWN				2. USUAL RESIDENCE (HOME) OF DECEASED STATE D.C. Md. COUNTY Pr. Georges CITY (If outside corporate limits, write RURAL and give nearest town) Temple Hills Park TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6491 Hemlock Place				STREET ADDRESS (If rural give location) 6491 Hemlock Place			
3. NAME OF DECEASED (Type or Print) (First) Florence (Middle) Anita (Last) McCall				4. DATE OF DEATH (Month) (Day) (Year) June 13, 1956			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, widowed	8. DATE OF BIRTH Jan 10, 1886	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James K. Garner				14. MOTHER'S MAIDEN NAME Louise Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) - -no		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS Wm. D. McCall, 6491 Hemlock Place, Temple Hills Park, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) myocardial infarction						1 mo.	
ANTECEDENT CAUSE(S) DUE TO (B) coronary arteriosclerosis						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) -							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus						7 yrs.	
19a. DATE OF OPERATION -		19b. MAJOR FINDINGS OF OPERATION -				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> P. <input type="checkbox"/> A. <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 5/16/56 to 6/13/56 , that I last saw the deceased alive on 6/13/56 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.							
SIGNATURE William C. Samant				ADDRESS (Street, city, town, state) 1418 3rd Ave. S.E. D.C. DATE SIGNED 6/13/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 6/16/56		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24. REC'D BY REGISTRAR W. W. Hines		REGISTRAR'S SIGNATURE W. W. Hines		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 11th St. N.W. Washington, D.C.			

CERTIFICATE OF DEATH

Reg. Form No. 1

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 40	
PLACE OF BIRTH Baltimore, Md.		RACE White		DATE OF BIRTH Jan 10, 1926	
PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Coronary Thrombosis		DATE OF DEATH Jan 10, 1956	
TIME OF DEATH 10:00 AM		PLACE OF INTERMENT St. Ignace Cemetery		DATE OF INTERMENT Jan 12, 1956	
NAME OF PHYSICIAN Dr. J. H. Harris		NAME OF FUNERAL HOME J. H. Harris		NAME OF NEXT OF KIN J. H. Harris	
NAME OF WITNESS J. H. Harris		NAME OF WITNESS J. H. Harris		NAME OF WITNESS J. H. Harris	

BUREAU V. H.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06464

CERTIFICATE OF DEATH

Reg. Dist. No.

6461

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp</u>				d. STREET ADDRESS <u>8000 Walker Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Medley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-56</u>		9. AGE (In years lost birthday) yrs. <u>2</u> Min. <u>25</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nelson Ford</u>				14. MOTHER'S MAIDEN NAME <u>Margaret medley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>mother - as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO <u>Prenatality</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>56</u> , to <u>6/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>56</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				M.D. <u>5301 Harwich St. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				DATE SIGNED <u>6/12/56</u>			
22. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Rd. S.E. W.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons, Inc. 467 N St., N.W.</u>				24a. REC'D BY REGISTRAR <u>JUN 27 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>J. D. Church</u>			

BUREAU V.

UN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06465

6462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MALE</u> <u>Infant</u> <u>Middleton</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>26</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1956</u>	
				9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
				11. BIRTHPLACE (State or foreign country) <u>md.</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>James Brown</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Middleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>mother - as above</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-23, 1956</u> , to <u>6-26, 1956</u> , that I last saw the deceased alive on <u>6/26, 1956</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D.				ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Md.</u> DATE SIGNED <u>6/26/56</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>June 28, 1956</u>		<u>Holy Trinity</u>		<u>Near Dares H.C. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely 401 Wash Ave Laurel Md.</u>				24. REC'D BY REGISTRAR <u>J. W. Perkins</u> 24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is filled out with handwritten text.

NAME: *John Doe*
DATE: *July 3, 1956*
TIME: *10:00 AM*
PLACE: *Home*
CAUSE: *Heart Disease*
SIGNATURE: *[Signature]*

RECEIVED
JUL 3 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6414

CERTIFICATE OF DEATH

06466

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 9202 - 49 Ave</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY EDWARD MILES</u> First <u>Henry</u> Middle <u>E.</u> Last <u>Miles</u>		4. DATE OF DEATH <u>June 15 1956</u> Day <u>15</u> Month <u>June</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Bond writer Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Miles</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Sierce</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>161-10-4965</u>		17. INFORMANT <u>Neil Miles</u> Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arricular Fibrillation</u> DUE TO (c) <u>Arterio-sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month, Day, Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1952</u> to <u>June 1956</u> that I last saw the deceased alive on <u>6-2</u> 19 <u>56</u> and that death occurred at <u>7:15</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		DATE SIGNED <u>4713 - Thompson Rd</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		<u>College Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Weaver Son 805 N. Calvert St.</u>		24a. REC'D BY REGISTRAR <u>June 16 - 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>R. W. John. D. Smith</u>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1956 JUN 18	
NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		RACE [Faint handwritten race]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		PLACE OF DEATH [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]	
DATE OF SIGNATURE [Faint handwritten date]		DATE OF SIGNATURE [Faint handwritten date]	

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6463

CERTIFICATE OF DEATH

07516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>mitchellville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen.</u>		d. STREET ADDRESS <u>Route 2 - Box 86</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Male Infant Mills</u>		4. DATE OF DEATH Month Day Year <u>June 15, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1956</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Kenneth James mills</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Delores Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>mother - as above</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Catelectosis</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>6/1/57</u> , 1956, to <u>6/15</u> , 1956, that I last saw the deceased alive on <u>6/15</u> , 1956, and that death occurred at <u>7:05 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D. <u>5301 Hamlet St.</u>		DATE SIGNED <u>6/26/56</u>	
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>		<u>Horton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>July 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges</u>		22d. LOCATION (City, town, or county) (State) <u>Chesley Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel R. Remick</u> ADDRESS <u>Adm</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>June 21, 1956</u>		<u>—</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF BURIAL OFFICER [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF [Faint text] [Faint text]	

RECEIVED
 JUL 12 1956
 BUREAU V. S.

Pr. ୮୧୦

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Year

Months	Days	Hours	Min
--------	------	-------	-----

12. CITIZEN OF WHAT COUNTRY?

Frances Miles

Address _____

INTERVAL BETWEEN ONSET AND DEATH	2 DAYS
-------------------------------------	--------

3 YRS

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

(State)

21. I certify that I attended the deceased from AUG., 1955, to JUNE 2, 1956, that I last saw the deceased alive on JUNE 2, 1956, and that death occurred at 7:15 AM, from the causes and on the date stated above.

DATE SIGNED _____

RIVERDALE MD

(State)

24b. REGISTRAR'S SIGNATURE

A 34

M.D. STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

1956 9 JUN

RECEIVED

6465

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Roberts Mullikin				4. DATE OF DEATH Month Day Year June 20 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/72	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Roberts				14. MOTHER'S MAIDEN NAME Henrietta Morsell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (son) Kent R. Mullikin, Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Laurel, Md.		(County) (State)	
21. I certify that I attended the deceased from January, 1946, to 6/20/56, 19, that I last saw the deceased alive on 6/19, 19 56, and that death occurred at 12:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S. McCeney M.D.				ADDRESS (Street, city or town, state) 402 MAIN ST. LAUREL, MD.			
DATE SIGNED 6/20/56							
PHYSICIAN'S NAME (Type) ROBERT S. MCCENEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity		22d. LOCATION (City, town, or county) (State) Mitchellville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bullitt Lindstrom				ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR DATE June 26 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severel Deputy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL SECURITY NUMBER [Faint text]		12. MOTHER'S MAIDEN NAME [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]		16. CAUSE OF DEATH [Faint text]		17. MANNER OF DEATH [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]	
19. SIGNATURE OF REGISTRAR [Faint text]		20. SIGNATURE OF WITNESS [Faint text]		21. SIGNATURE OF SECOND WITNESS [Faint text]		22. SIGNATURE OF THIRD WITNESS [Faint text]		23. SIGNATURE OF FOURTH WITNESS [Faint text]		24. SIGNATURE OF FIFTH WITNESS [Faint text]	
25. SIGNATURE OF SIXTH WITNESS [Faint text]		26. SIGNATURE OF SEVENTH WITNESS [Faint text]		27. SIGNATURE OF EIGHTH WITNESS [Faint text]		28. SIGNATURE OF NINTH WITNESS [Faint text]		29. SIGNATURE OF TENTH WITNESS [Faint text]		30. SIGNATURE OF ELEVENTH WITNESS [Faint text]	
31. SIGNATURE OF TWELFTH WITNESS [Faint text]		32. SIGNATURE OF THIRTEENTH WITNESS [Faint text]		33. SIGNATURE OF FOURTEENTH WITNESS [Faint text]		34. SIGNATURE OF FIFTEENTH WITNESS [Faint text]		35. SIGNATURE OF SIXTEENTH WITNESS [Faint text]		36. SIGNATURE OF SEVENTEENTH WITNESS [Faint text]	
37. SIGNATURE OF EIGHTEENTH WITNESS [Faint text]		38. SIGNATURE OF NINETEENTH WITNESS [Faint text]		39. SIGNATURE OF TWENTIETH WITNESS [Faint text]		40. SIGNATURE OF TWENTY-FIRST WITNESS [Faint text]		41. SIGNATURE OF TWENTY-SECOND WITNESS [Faint text]		42. SIGNATURE OF TWENTY-THIRD WITNESS [Faint text]	
43. SIGNATURE OF TWENTY-FOURTH WITNESS [Faint text]		44. SIGNATURE OF TWENTY-FIFTH WITNESS [Faint text]		45. SIGNATURE OF TWENTY-SIXTH WITNESS [Faint text]		46. SIGNATURE OF TWENTY-SEVENTH WITNESS [Faint text]		47. SIGNATURE OF TWENTY-EIGHTH WITNESS [Faint text]		48. SIGNATURE OF TWENTY-NINTH WITNESS [Faint text]	
49. SIGNATURE OF THIRTIETH WITNESS [Faint text]		50. SIGNATURE OF THIRTY-FIRST WITNESS [Faint text]		51. SIGNATURE OF THIRTY-SECOND WITNESS [Faint text]		52. SIGNATURE OF THIRTY-THIRD WITNESS [Faint text]		53. SIGNATURE OF THIRTY-FOURTH WITNESS [Faint text]		54. SIGNATURE OF THIRTY-FIFTH WITNESS [Faint text]	
55. SIGNATURE OF THIRTY-SIXTH WITNESS [Faint text]		56. SIGNATURE OF THIRTY-SEVENTH WITNESS [Faint text]		57. SIGNATURE OF THIRTY-EIGHTH WITNESS [Faint text]		58. SIGNATURE OF THIRTY-NINTH WITNESS [Faint text]		59. SIGNATURE OF FORTIETH WITNESS [Faint text]		60. SIGNATURE OF FORTY-FIRST WITNESS [Faint text]	
61. SIGNATURE OF FORTY-SECOND WITNESS [Faint text]		62. SIGNATURE OF FORTY-THIRD WITNESS [Faint text]		63. SIGNATURE OF FORTY-FOURTH WITNESS [Faint text]		64. SIGNATURE OF FORTY-FIFTH WITNESS [Faint text]		65. SIGNATURE OF FORTY-SIXTH WITNESS [Faint text]		66. SIGNATURE OF FORTY-SEVENTH WITNESS [Faint text]	
67. SIGNATURE OF FORTY-EIGHTH WITNESS [Faint text]		68. SIGNATURE OF FORTY-NINTH WITNESS [Faint text]		69. SIGNATURE OF FIFTIETH WITNESS [Faint text]		70. SIGNATURE OF FIFTY-FIRST WITNESS [Faint text]		71. SIGNATURE OF FIFTY-SECOND WITNESS [Faint text]		72. SIGNATURE OF FIFTY-THIRD WITNESS [Faint text]	
73. SIGNATURE OF FIFTY-FOURTH WITNESS [Faint text]		74. SIGNATURE OF FIFTY-FIFTH WITNESS [Faint text]		75. SIGNATURE OF FIFTY-SIXTH WITNESS [Faint text]		76. SIGNATURE OF FIFTY-SEVENTH WITNESS [Faint text]		77. SIGNATURE OF FIFTY-EIGHTH WITNESS [Faint text]		78. SIGNATURE OF FIFTY-NINTH WITNESS [Faint text]	
79. SIGNATURE OF SIXTIETH WITNESS [Faint text]		80. SIGNATURE OF SIXTY-FIRST WITNESS [Faint text]		81. SIGNATURE OF SIXTY-SECOND WITNESS [Faint text]		82. SIGNATURE OF SIXTY-THIRD WITNESS [Faint text]		83. SIGNATURE OF SIXTY-FOURTH WITNESS [Faint text]		84. SIGNATURE OF SIXTY-FIFTH WITNESS [Faint text]	
85. SIGNATURE OF SIXTY-SIXTH WITNESS [Faint text]		86. SIGNATURE OF SIXTY-SEVENTH WITNESS [Faint text]		87. SIGNATURE OF SIXTY-EIGHTH WITNESS [Faint text]		88. SIGNATURE OF SIXTY-NINTH WITNESS [Faint text]		89. SIGNATURE OF SEVENTIETH WITNESS [Faint text]		90. SIGNATURE OF SEVENTY-FIRST WITNESS [Faint text]	
91. SIGNATURE OF SEVENTY-SECOND WITNESS [Faint text]		92. SIGNATURE OF SEVENTY-THIRD WITNESS [Faint text]		93. SIGNATURE OF SEVENTY-FOURTH WITNESS [Faint text]		94. SIGNATURE OF SEVENTY-FIFTH WITNESS [Faint text]		95. SIGNATURE OF SEVENTY-SIXTH WITNESS [Faint text]		96. SIGNATURE OF SEVENTY-SEVENTH WITNESS [Faint text]	
97. SIGNATURE OF SEVENTY-EIGHTH WITNESS [Faint text]		98. SIGNATURE OF SEVENTY-NINTH WITNESS [Faint text]		99. SIGNATURE OF EIGHTIETH WITNESS [Faint text]		100. SIGNATURE OF EIGHTY-FIRST WITNESS [Faint text]		101. SIGNATURE OF EIGHTY-SECOND WITNESS [Faint text]		102. SIGNATURE OF EIGHTY-THIRD WITNESS [Faint text]	
103. SIGNATURE OF EIGHTY-FOURTH WITNESS [Faint text]		104. SIGNATURE OF EIGHTY-FIFTH WITNESS [Faint text]		105. SIGNATURE OF EIGHTY-SIXTH WITNESS [Faint text]		106. SIGNATURE OF EIGHTY-SEVENTH WITNESS [Faint text]		107. SIGNATURE OF EIGHTY-EIGHTH WITNESS [Faint text]		108. SIGNATURE OF EIGHTY-NINTH WITNESS [Faint text]	
109. SIGNATURE OF NINETY WITNESS [Faint text]		110. SIGNATURE OF NINETY-FIRST WITNESS [Faint text]		111. SIGNATURE OF NINETY-SECOND WITNESS [Faint text]		112. SIGNATURE OF NINETY-THIRD WITNESS [Faint text]		113. SIGNATURE OF NINETY-FOURTH WITNESS [Faint text]		114. SIGNATURE OF NINETY-FIFTH WITNESS [Faint text]	
115. SIGNATURE OF NINETY-SIXTH WITNESS [Faint text]		116. SIGNATURE OF NINETY-SEVENTH WITNESS [Faint text]		117. SIGNATURE OF NINETY-EIGHTH WITNESS [Faint text]		118. SIGNATURE OF NINETY-NINTH WITNESS [Faint text]		119. SIGNATURE OF HUNDRED WITNESS [Faint text]		120. SIGNATURE OF HUNDRED AND ONE WITNESS [Faint text]	

BUREAU V. R.

JUN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06469
232

1. PLACE OF DEATH a. COUNTY Prince Georges! MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince Georges!	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		d. STREET ADDRESS Rt. 2, Box 184	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 2, Box 184		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Alexander Mullikin		4. DATE OF DEATH Month Day Year June 5 1956.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1874
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenent	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Henry Mullikin		14. MOTHER'S MAIDEN NAME Mary Alice Goddard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lillie Virginia Mullikin		Address Rt. 2, Box 184 Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1956 to 5 June 1956, that I last saw the deceased alive on 4 June 1956, and that death occurred at 6:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Sasser		ADDRESS (Street, city or town, state) Upper Marlboro Md	
PHYSICIAN'S NAME (Type) Robert B. Sasser, M.D.		DATE SIGNED June 7-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/56	
22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE 6/7/56		24b. REGISTRAR'S SIGNATURE John F Sanner	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MEDICAL HISTORY [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF REGISTRAR [Illegible]		12. DATE OF DEATH [Illegible]	

Attorney General's Office

12 Jan

RECEIVED
Supp. Bureau V. 2
30 Dec 20

Robert D. Jones
4 Jan 20
Feb

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 198 6-15-56 et

6526

CERTIFICATE OF DEATH

Reg. Dist. No.

064711

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE CROSBY NALLEY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 11 1956</u>								
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u> <u>SEPT 6, 1889</u>	9. AGE (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE OWN HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>GAMBRIL CROSBY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>GABRIEL E NALLEY-BOWIE MD (SON)</u> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MINUTES</u> <u>YEARS</u>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> No, while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____						
21. I certify that I attended the deceased from <u>JAN 3</u> , 19 <u>55</u> , to <u>PRESENT</u> , 19____, that I last saw the deceased alive on <u>JUNE 4</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.												
ACTUAL SIGNATURE <u>John R. Buell</u>				DATE SIGNED <u>6/11/56</u>								
PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>				ADDRESS (Street, city or town, state) <u>402 Main St Laurel Md.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or county) <u>White Marsh, Md</u> (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch sons Hyattsville Md</u>				24. REC'D BY REGISTRAR <u>John W. Gungling</u>		24b. REGISTRAR'S SIGNATURE						

CERTIFICATE OF DEATH

REG. DIST. NO.

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE REGISTRAR	
NAME OF DECEASED		NAME OF DECEASED	
AGE		AGE	
SEX		SEX	
RACE		RACE	
DATE OF BIRTH		DATE OF BIRTH	
PLACE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		DATE OF REGISTRATION	
PLACE OF REGISTRATION		PLACE OF REGISTRATION	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF CLERGYMAN		SIGNATURE OF CLERGYMAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF BURIAL OFFICER		SIGNATURE OF BURIAL OFFICER	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF CLERGYMAN		SIGNATURE OF CLERGYMAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF BURIAL OFFICER		SIGNATURE OF BURIAL OFFICER	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. 1

JUN 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06471

6597

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

The correct age is especially important. Supply every item of information carefully. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
TOWN Glenn Dale Hospital and 3 days.		TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS D. C. Village (Home for Aged) ✓	
3. NAME OF DECEASED (First) EUGENE (Middle) H. (Last) ODEKOVEN		4. DATE OF DEATH JUNE 15 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11/14/1883
9. AGE last birthday 72 yrs.		10. If under 1 year 11. If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wine Steward		10b. KIND OF BUSINESS OR INDUSTRY Mayflower Hotel	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo Odekoven		14. MOTHER'S MAIDEN NAME Elizabeth Rorb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Unknown		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Decedent			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
57201 Immediate cause (a) Intestinal Obstruction		2 days	
Antecedent cause(s) (b) Peritonitis of Sigmoid Colon		Unknown	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 002x Arteriosclerotic Ht. Disease, Unknown; Pulmonary Tuberculosis 2 yrs, 3 mos; Diabetes Mellitus 10 yrs, 3 mos			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 6/14/56		19b. MAJOR FINDINGS OF OPERATION Cecostomy performed. Major findings: dilated loops of intestine	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/12, 1954, to 6/15, 1956, that I last saw the deceased alive on 6/15, 1956, and that death occurred at 12:05 P. m., from the causes and on the date stated above.			
SIGNATURE Daniel Leo Pincus M.D.		ADDRESS Glenn Dale Hospital Glenn Dale, Md. 6/15/56	
23. BURIAL OR CREMATION REMOVAL (Specify) Burial		DATE 6/18/56	
NAME OF CEMETERY OR CREMATORY Rock Creek		LOCATION (City, town, or county) Washington D.C. (State)	
DATE REC'D BY LOCAL REG. 6/15/56		REGISTRAR'S SIGNATURE Noel Green	
24. FUNERAL DIRECTOR 54 Ames Co		ADDRESS Washington D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED

JUN 26 1956

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06472

6466

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.		d. STREET ADDRESS 1217 51st Avenue	
3. NAME OF DECEASED (Type or print) Clarence Outlaw		4. DATE OF DEATH June 2 1956	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, '42
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Sidney Outlaw		14. MOTHER'S MAIDEN NAME Clara Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Clara Outlaw, Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot (22 cal.) wound of abdomen. (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in abdomen during an altercation	
20c. TIME OF INJURY Month, Day, Year 8.00 a.m. 6-2-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Deanwood Park, Pr. Geo., Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 3, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) Suitland Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle L. Collins		ADDRESS 4339 Hunt Pl., N.E.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

9561 8 NHP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6467
CERTIFICATE OF DEATH

06473
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 19			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial				d. STREET ADDRESS 430 Oglethorpe St N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Slater		First Middle Last		4. DATE OF DEATH		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1900	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR		Months Days Hours Min.		26 1956	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Clerk				10b. KIND OF BUSINESS OR INDUSTRY Agriculture Dept.			
11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Dilbert Hoover Overdorff				14. MOTHER'S MAIDEN NAME Lucy Melinda Spalmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service unknown				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records				Address Riverdale, Md. 4408 Queensberry Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma of Liver metastatic DUE TO primary site undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 mo. INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 26, 1956, to June 26, 1956, that I last saw the deceased alive on June 26, 1956, and that death occurred at 9 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L.W. Malin M.D.				ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 9-26-56			
PHYSICIAN'S NAME (Type) L. W. Malin M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. NW				24a. REC'D BY REGISTRAR DATE 6-28-1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME OF DECEASED JAMES E. SMITH		DATE OF DEATH JUL 1 1956	
AGE 45		SEX M	
RACE W		EDUCATION H	
OCCUPATION Carpenter		RESIDENCE 1234 Main St, Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
PLACE OF DEATH Home		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	
DATE OF SIGNATURE JUL 1 1956		DATE OF SIGNATURE JUL 1 1956	

RECEIVED
JUL 2 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06474

6422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges 3801 42nd Ave MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY Prince Georges 6224 42nd Ave N.E. Hyattsville Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	c. LENGTH OF STAY IN 1b 1 Mo 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	d. STREET ADDRESS 6224 42nd Ave
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine		4. DATE OF DEATH June 5 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1915
9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Biernaga		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Blank]	
17. INFORMANT Mr. S. A. Porlino		Address (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular DUE TO (c) renal disease		INTERVAL BETWEEN ONSET AND DEATH 10 hrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-28-54, 19, to 6-5-54, 19, that I last saw the deceased alive on 6-5-54, 19, and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John R. Clum		DATE SIGNED June 6-5-54	
PHYSICIAN'S NAME (Type) Dr. John R. Clum		ADDRESS (Street, city or town, state) Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-56	
22c. NAME OF CEMETERY OR CREMATORY East River Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee, Sr.		24. REC'D BY REGISTRAR June 7 1956	
ADDRESS 44th Man Ave N.E. Wash D.C.		24b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06475

6468

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P. Hr.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Brentwood Md. 34			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4531 Banner St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE First Middle Last PATTERSON				4. DATE OF DEATH June 12 1956			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 6, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME CHARLIE SKERER				14. MOTHER'S MAIDEN NAME NANCY THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 4531			
17. INFORMANT MRS Ethel Lander (daughter) Brentwood				Address 4531 Banner St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 593X DUE TO (b) Nephritis & Hypertension DUE TO (c) Hemiplegia - Rt. Side Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 6-1-56 1950 5-27-56
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9-56, to 6-12-56, that I last saw the deceased alive on 6-12-56, and that death occurred at 2:35 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. W. Spiller				M.D. 4506 R. L. Ave. BRENTWOOD			
PHYSICIAN'S NAME (Type) William W. Spiller				DATE SIGNED 6/12/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-15-56		22c. NAME OF CEMETERY OR CREMATORY Shadlow		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Funeral Home Inc. Wash. DC				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE A. W. Hancock	

RECEIVED

BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6469

CERTIFICATE OF DEATH

Reg. Dist. No.

064265

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital				d. STREET ADDRESS Route 2			
3. NAME OF DECEASED (Type or print) First Russell Middle Leo Last Paul				4. DATE OF DEATH Month June 26 , 1956 Day 19 Year 19			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1923	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept Manager		10b. KIND OF BUSINESS OR INDUSTRY Food store		11. BIRTHPLACE (State or foreign country) Penn. Tionesta, Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry Paul				14. MOTHER'S MAIDEN NAME Rachel Stroup			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 2		16. SOCIAL SECURITY NO. 174 16 6589		17. INFORMANT Mrs. Esther Paul, Rt 2, Laurel, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 193X IMMEDIATE CAUSE (a) Glioblastoma Multiforme DUE TO (b) _____ Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25 , 1956, to June 26 , 1956, that I last saw the deceased alive on June 26 , 1956, and that death occurred at 11:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John R. Buell				ADDRESS (Street, city or town, state) 402 Main St., Laurel, Maryland DATE SIGNED 6/27/56			
PHYSICIAN'S NAME (Type) John R. Buell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1956		22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Haddock ADDRESS Laurel, Md.				24a. REC'D BY REGISTRAR July 3, 1956 DATE		24b. REGISTRAR'S SIGNATURE Wm. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 5 1956
BUREAU V. S.

JUL 5 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 230

6598

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGES.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERWYN HTS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERWYN HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5815 GREENBELT RD.</u>		d. STREET ADDRESS <u>5815 GREENBELT RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>ADELAIDE</u> Middle <u>ADAMS</u> Last <u>PHILIPS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ZERI A. ADAMS</u>		14. MOTHER'S MAIDEN NAME <u>ALICE CORY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS ALICE P. BURHOE, 5815 GREENBELT RD. MD.</u>		Address <u>BERWYN HTS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure due to</u> DUE TO <u>Arteriosclerotic CV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO <u>?</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955 3</u> 19 <u>56</u> to <u>June 20, 1956</u> that I last saw the deceased alive on <u>June 14, 1956</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul E. Janet, M.D.</u>		DATE SIGNED <u>6-22-56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL E. JANET, M.D.</u>		ADDRESS (Street, city or town, state) <u>6727 16th St. S.E. Md 20056</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 23, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>	22d. LOCATION (City, town or county) (State) <u>PR GEO CO Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Smith</u>		ADDRESS <u>TAKOMA PARK, DC</u>	
24a. REC'D BY REGISTRAR <u>John D. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	
DATE <u>6-22-56</u>		DATE <u>6-22-56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06478

6599

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Glenn Dale (rural) TOWN Glenn Dale (rural) and HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) Washington TOWN Washington STREET ADDRESS 1536 Kingman Place, N. W.	
3. NAME OF DECEASED (Type or Print) (First) EDWARD (Middle) (Last) QUEEN		4. DATE OF DEATH (Month) JUNE (Day) 1 (Year) 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH 6/12/20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Brookland Coal Co.	9. AGE last birthday 35 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warner Queen		14. MOTHER'S MAIDEN NAME Ada Belle McPherson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. 577-26-0402	
17. INFORMANT AND ADDRESS Decedent			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Pulmonary Tuberculosis				2 yrs 4 mos	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY OCCURRED While at Work Not While At work		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from 4/25, 1956, to 6/1, 1956, that I last saw the deceased alive on 5/31, 1956, and that death occurred at 6:25 A.M., from the causes and on the date stated above.		SIGNATURE Daniel L. Pincane M.D.		ADDRESS Glenn Dale Hospital Glenn Dale, Md. DATE SIGNED 6/1/56	
23. BURIAL, CREMATION REMOVAL (Specify) Removed		DATE 6/5/56		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Washington D.C.	
DATE REC'D BY LOCAL REG. 6/1/56		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR 20. Ernest Jarvis Co 1432 2nd St Wash. D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06479

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>Dead on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial</u>				d. STREET ADDRESS <u>620 8th Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Rosalin</u> Middle <u>Marie</u> Last <u>Reese</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH			
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>James E. Reese</u>			
14. MOTHER'S MAIDEN NAME <u>Lelia Jackson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>James E. Reese same address as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 16</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Muirkirk</u>			
22d. LOCATION (City, town, or county) <u>Prince George Md</u>		24a. REC'D BY REGISTRAR <u>June 15 1956</u>					
24b. REGISTRAR'S SIGNATURE <u>Mr. Jas. Berres</u>		24c. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u>					
ADDRESS <u>401 Wash Blvd</u>		24d. REGISTRAR'S SIGNATURE <u> </u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUROU A. S.

9561 0 100

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06480

6510

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pringe George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunnybrook Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunnybrook Md</u>	
c. LENGTH OF STAY IN 1b <u>9 years</u>		d. STREET ADDRESS <u>4303 55th avenue.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4303 55th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Gridlin Ripley</u>		4. DATE OF DEATH Month Day Year <u>June 29, 19 56.</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Architect</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U SA</u>	
13. FATHER'S NAME <u>David Ripley</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Katharine Ripley</u>		Address <u>Sunnybrook, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure - chronic nephritis</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Cardiovascular Renal disease</u> DUE TO (c) <u>2 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>54</u> , to <u>6-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-27</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd</u> <u>13 Ladensburg Trl</u>	
PHYSICIAN'S NAME (Type) <u>DAYTON O. WATKINS</u>		DATE SIGNED <u>8-9-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>8/1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Camden</u>		22d. LOCATION (City, town, or county) (State) <u>New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24d. REC'D BY REGISTRAR <u>8-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Madrech</u>	

6511

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 7 Gallatville Md 9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 1517.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Branch Nursing Home</u>		d. STREET ADDRESS <u>123 Grant Cve</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Paul Roseman</u>		4. DATE OF DEATH <u>June 29 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURNACE Fireman at School</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y. City</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Prince Branch Nursing Home</u>		Address <u>Beard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>1931</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6/1/56</u> <u>+6/29/56</u> <u>1931</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2/35</u> , to <u>6/29/56</u> , that I last saw the deceased alive on <u>6/28/56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carroll Cve</u> DATE SIGNED <u>6/29/56</u>	
PHYSICIAN'S NAME (Type) <u>H. T. Morse M.D.</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY, COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>July 2, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Serrano</u> Deputy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Robert Lawrence Jones		35		Male	
Date of Death		Place of Death		Cause of Death	
July 1, 1956		Boston, Mass.		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

Name of Deceased		Age		Sex	
John Robert Lawrence Jones		35		Male	
Date of Death		Place of Death		Cause of Death	
July 1, 1956		Boston, Mass.		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

Name of Deceased		Age		Sex	
John Robert Lawrence Jones		35		Male	
Date of Death		Place of Death		Cause of Death	
July 1, 1956		Boston, Mass.		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

RECEIVED

JUL 5 1956

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06482

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN 1b 2 1/2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3408 43rd Avenue				d. STREET ADDRESS 3408 43rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Augusta Middle Rossman Last Rossman				4. DATE OF DEATH Month June Day 26 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1888		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Green Colmar Manor Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 26, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR June 26, 1956	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUL 3 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 245

6424

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier				c. LENGTH OF STAY IN 1b transit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Office of Dr. Geo. Hageage				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dale Middle Schimpf Last Schimpf				4. DATE OF DEATH Month June Day 6 Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1955	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 5		IF UNDER 24 HRS. Hours 5 Min. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jerome Schimpf				14. MOTHER'S MAIDEN NAME Rita Sheldon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Jerome Schimpf, Same address.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach contents DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Choked on regurgitated food			
20c. TIME OF INJURY Month, Day, Year Hour 6-6-56 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Hyattsville, Pr. Geo., Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney? M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/8/56			
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				22d. LOCATION (City, town, or county) (State) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland			
24a. REC'D BY REGISTRAR 6-11-56				24b. REGISTRAR'S SIGNATURE James C. Livers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 11 1956

RECEIVED

6471

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN lb 40 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dearfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Lee Last Schmidt				4. DATE OF DEATH Month 6 Day 30 Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1885	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Smith		14. MOTHER'S MAIDEN NAME Nanny Diarty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Ritta Hodge, Richmond, Virginia.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Congestive heart failure (c) Coronary occlusion DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 30, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/56		22c. NAME OF CEMETERY OR CREMATORY Warm Springs		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR J. K. W. [Signature]				24b. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JUL 3 1956

BUREAU V. 8

MD-100 (Rev. 1-55)

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF DEATH: _____

5. TIME OF DEATH: _____

6. PLACE OF DEATH: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF EXAMINER: _____

10. TITLE OF EXAMINER: _____

11. ADDRESS OF EXAMINER: _____

12. CITY: _____

13. STATE: _____

14. ZIP CODE: _____

15. COUNTY: _____

16. DISTRICT: _____

17. WARD: _____

18. BLOCK: _____

19. LOT: _____

20. SUBLOT: _____

21. PARCEL: _____

22. TRACT: _____

23. SECTION: _____

24. TOWNSHIP: _____

25. COUNTY: _____

26. STATE: _____

27. ZIP CODE: _____

28. CITY: _____

29. DISTRICT: _____

30. WARD: _____

31. BLOCK: _____

32. LOT: _____

33. SUBLOT: _____

34. PARCEL: _____

35. TRACT: _____

36. SECTION: _____

37. TOWNSHIP: _____

38. COUNTY: _____

39. STATE: _____

40. ZIP CODE: _____

41. CITY: _____

42. DISTRICT: _____

43. WARD: _____

44. BLOCK: _____

45. LOT: _____

46. SUBLOT: _____

47. PARCEL: _____

48. TRACT: _____

49. SECTION: _____

50. TOWNSHIP: _____

51. COUNTY: _____

52. STATE: _____

53. ZIP CODE: _____

54. CITY: _____

55. DISTRICT: _____

56. WARD: _____

57. BLOCK: _____

58. LOT: _____

59. SUBLOT: _____

60. PARCEL: _____

61. TRACT: _____

62. SECTION: _____

63. TOWNSHIP: _____

64. COUNTY: _____

65. STATE: _____

66. ZIP CODE: _____

67. CITY: _____

68. DISTRICT: _____

69. WARD: _____

70. BLOCK: _____

71. LOT: _____

72. SUBLOT: _____

73. PARCEL: _____

74. TRACT: _____

75. SECTION: _____

76. TOWNSHIP: _____

77. COUNTY: _____

78. STATE: _____

79. ZIP CODE: _____

80. CITY: _____

81. DISTRICT: _____

82. WARD: _____

83. BLOCK: _____

84. LOT: _____

85. SUBLOT: _____

86. PARCEL: _____

87. TRACT: _____

88. SECTION: _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G199 6-27-56 et

06485

6513

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE 3216 - 76th Ave Kentland Md. b. COUNTY Kentland Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hyattsville Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3216 - 76th Ave Kentland Md.				d. STREET ADDRESS 3216 - 76th Ave Kentland Md.			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph CARROLL SE764				4. DATE OF DEATH June 20 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1894 Dec 25 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles H. Selby				14. MOTHER'S MAIDEN NAME Mary Doyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Joseph E. Selby - 3216 - 76th Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's Cirrhosis (c) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 1 month 4 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis (activity undetermined)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1 Jun, 1956, to 20 Jun 1956, that I last saw the deceased alive on 20 Jun 56, and that death occurred at 9:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney M.D.				ADDRESS (Street, city or town, state) 4814 - 71st Ave. Cardona Hill Md.			
DATE SIGNED 40 years				22. NAME OF CEMETERY OR CREMATORY			
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Lee's Sons Co 300 - 4th				24a. REC'D BY REGISTRAR DATE 6-22-56			
24b. REGISTRAR'S SIGNATURE A. W. Hedrick				25. LOCATION (City, town, or county) (State) Suitland Md.			

BUREAU V. S.

JUN 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07537

Reg. Dist. No. 243

6514

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 414 6 1/2 St., S. W.	
3. NAME OF DECEASED (First) LOUISE (Middle) SETTLES (Last)		4. DATE OF DEATH June 29, 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Common-law, not living together	8. DATE OF BIRTH 2/11/15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. FATHER'S NAME Daniel Settles		11. BIRTHPLACE (State or foreign country) Virginia	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. SOCIAL SECURITY No. 579-30-5175	
13. FATHER'S NAME Daniel Settles		14. MOTHER'S MAIDEN NAME Annie Mae Steppin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		15. INFORMANT AND ADDRESS Decedent	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 mo.
Immediate cause (a) Pulmonary Tuberculosis		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/14, 1956, to 6/29, 1956, that I last saw the deceased

alive on June 29, 1956, and that death occurred at 2:05 P. m., from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Glenn Dale Hospital Glenn Dale, Md. DATE SIGNED 6/29/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 7/7/56	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
DATE RECD BY LOCAL REG. 6/29/56	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JUL 11 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06486

6515

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George		MARYLAND		STATE Md.		COUNTY Prince George	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Oxon Hill		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Oxon Hill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 5125--Shago Lane			
3. NAME OF DECEASED (Type or Print) CLARA C. SHERIFF				4. DATE OF DEATH (Month) (Day) (Year) June 14th 19 56			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Dec. 29-1889	
				9. AGE last birthday 66 yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George M. Higbee				14. MOTHER'S MAIDEN NAME Clara Hamden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Thomas N. Sheriff 5125--Shago Lane, Oxon Hill, Md. Husband	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebro-vascular accident				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension & arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 13, 1956, to June 14, 1956, that I last saw the deceased alive on June 13, 1956, and that death occurred at 7:02 P.M. from the causes and on the date stated above.							
SIGNATURE Hester L. Hester				DATE SIGNED June 14, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF June 16th-56		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
				LOCATION (City, town, or county) Suitland		6-1X-57 (State) Md.	
24. REC'D BY REGISTRAR June 14-56				REGISTRAR'S SIGNATURE Edna F. Gellman		25. FUNERAL DIRECTOR'S SIGNATURE 1661-Good Hope Rd., SE Washington DC	

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR OF VITAL RECORDS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		MASSACHUSETTS		BOSTON		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JANUARY 1, 1925		BOSTON		MASSACHUSETTS		UNITED STATES		JANUARY 1, 1925		BOSTON		MASSACHUSETTS		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		MARRIED		3		NONE	
SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 2

JAN 1 1925

RECEIVED

MASSACHUSETTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06487

Item 13 Film 6-26-56 ge CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>5006 Nicholson Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Zilphia</u> First <u>Matilda Beulah</u> Middle <u>Shoemaker</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1891</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noah</u> (<u>Unknown</u>) <u>Vaughn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clemmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lemuel I.H. Shoemaker</u>		Address <u>5006 Nicholson St. Riverdale</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of inferior vena cava</u> DUE TO (c) <u>Chronic adhesive pericarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple duodenal ulcers</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 June, 1956</u> , to <u>14 June, 1956</u> , that I last saw the deceased alive on <u>14 June, 1956</u> , and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.B. Sasscer</u>		ADDRESS (Street, city or town, state) <u>Upper Marlboro Md.</u> DATE SIGNED <u>6-15-56</u>	
PHYSICIAN'S NAME (Type) <u>R.B. Sasscer</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>	
24b. REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 68		SEX Male		RACE White		DATE OF BIRTH 1887		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Retired		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH June 18, 1956		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		TEMPERATURE 100.0		PULSE 90		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris, J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEAREST RELATIVE J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	
DATE OF REGISTRATION June 19, 1956		PLACE OF REGISTRATION Baltimore, Md.		TIME OF REGISTRATION 10:30 AM		TEMPERATURE 100.0		PULSE 90		RESPIRATION 20	

BUREAU V. S.

JUN 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Connecticut</u> b. COUNTY <u>Fairfield</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bridgeport Connecticut</u> <u>45X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>112 George St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Allan</u> <u>Singley</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>1</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 22, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bridgeport Brass Co</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Albert Singley</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Julius Singley</u> <u>80 Robin St</u> <u>Bridgeport Conn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest, fracture of the right femur</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of an automobile that was in a collision with another auto.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1:25</u> <u>PM</u> <u>June 1, 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> <u>at work</u> <u>at work</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route # 301</u>		20f. (City or town) (County) (State) <u>Cheltenham P. G.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 1, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bridgeport</u>		22d. LOCATION (City, town, or county) (State) <u>Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 4 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>A. H. Zdrach</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SECRET - 7c NOA

BUREAU V. S.

RECEIVED

6474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Choral, Md.</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>				e. STREET ADDRESS <u>2722 73rd Place</u>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Boulton</u> Middle <u>Smedes</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manager</u>		11. BIRTHPLACE (State or foreign country) <u>Jersey City N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Richard Broadhead</u>				14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Therese G. Smedes</u> Address <u>Kent Village, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>L.A. NECROSIS OF LIVER</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Colmar Manor, Md.</u>		(County) (State)		
21. I certify that I attended the deceased from <u>MAY 17</u> , 19 <u>56</u> to <u>JUNE 23</u> , 19 <u>56</u> what I last saw the deceased alive on <u>JUNE 23</u> , 19 <u>56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u>		M.D. <u>3503 Perry St. MT PLAIN MD 6/23/56</u>		DATE SIGNED <u>6/23/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u>		<u>3503 PERRY ST MT PLAIN MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 26, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Bedrich</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Upper Marlboro</u>	
3. NAME OF DECEASED (Type or print) <u>Male Infant</u> First Middle Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sara Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother - as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> DUE TO <u>Electrical</u> <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/26/56</u> to <u>6/26/56</u> , that I last saw the deceased alive on <u>6/26/56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>		DATE SIGNED <u>6/26/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen. Hosp. Cheverly Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins</u>		24a. REC'D BY REGISTRAR <u>5077182XVV</u>	
ADDRESS <u>5077182XVV</u>		24b. REGISTRAR'S SIGNATURE <u>5077182XVV</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06490

CERTIFICATE OF DEATH

Reg. Dist. No. 243

6516

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 717 11th St., N. W.	
3. NAME OF DECEASED (Type or Print) QUINTON E SMITH		4. DATE OF DEATH (Month) (Day) (Year) JUNE 2 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced	8. DATE OF BIRTH 5/23/95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper hanger and night clerk		10b. KIND OF BUSINESS OR INDUSTRY Royal Hotel	9. AGE last birthday 61 yrs.
13. FATHER'S NAME Flavious Smith		14. MOTHER'S MAIDEN NAME Agnes Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Unknown		16. SOCIAL SECURITY No. 578-09-3705	
17. INFORMANT AND ADDRESS Decedent		12. CITIZEN OF WHAT COUNTRY? USA	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
151X Immediate cause (a) Carcinoma of Stomach					3 weeks	
Antecedent cause(s)						
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			(b)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			(c) Pulmonary Tuberculosis		2 1/2 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)
SUICIDE HOMICIDE		INJURY		HOW DID INJURY OCCUR?		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Nnt While At wrk				
22. I hereby certify that I attended the deceased from 4/27, 1956, to 6/2, 1956, that I last saw the deceased alive on 6/1, 1956, and that death occurred at 6:25 A.M., from the causes and on the date stated above.						
SIGNATURE		ADDRESS		DATE SIGNED		
Daniel Leo Pinckney M.D.		Glenn Dale Hospital Glenn Dale, Maryland		6/1/56		
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
Burial		Washington National Cemetery		Suitland, Md		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		
6/2/56		Woe Weiss		W. W. Chambers Co. - Riverdale Md		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1956

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6517

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Glenn Dale (rural)		LENGTH OF STAY (in this place) 2 mos., & 5 days.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital				STREET ADDRESS (If rural, give location) 906 K. St., S. E.	
3. NAME OF DECEASED (Type or Print) (First) Caleb		(Middle) H.		(Last) Snowden	
4. DATE OF DEATH (Month) 6 (Day) 25 (Year) 1956		5. SEX Male		6. COLOR OR RACE Negro	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH 12/11/06		9. AGE last birthday 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lorenzo H. Snowden		14. MOTHER'S MAIDEN NAME Susie Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Unknown		16. SOCIAL SECURITY No. 579-07-3528		17. INFORMANT AND ADDRESS Decedent	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Adrenocortical Insufficiency		2 mo	
Antecedent cause(s) (b) Pulmonary Tuberculosis		6 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from 4/20, 1956, to 6/25, 1956, that I last saw the deceased

alive on 6/25, 1956, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Francis D. Costello Glenn Dale Md 6/25/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 6/27/56		NAME OF CEMETERY OR CREMATORY Woodlawn		LOCATION (City, town, or county) Washington, D.C.		(State)	
DATE REC'D BY LOCAL REG. 6/25/56		REGISTRAR'S SIGNATURE A. W. Allen		24. FUNERAL DIRECTOR R. M. Horton & 1322 10th St NW		ADDRESS			

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 5 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06492

6476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>38 Cheverly</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>near Washington, D.C.</i>	
3. NAME OF DECEASED (Type or print) First <i>Lottie</i> Middle <i>M.</i> Last <i>Boit</i>		d. STREET ADDRESS <i>5759 - 1st St. S.E.</i>	
4. DATE OF DEATH Month <i>6</i> Day <i>27</i> Year <i>1956</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>? 9/11/74</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Watson</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. Ethel Price</i>		Address <i>above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>550.1 Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ruptured appendix with abscess</i> DUE TO (c) <i>19 days</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>a. ft.</i> Month <i>19</i> Day <i>19</i> Year <i>1956</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 10, 1956</i> to <i>June 27, 1956</i> , that I last saw the deceased alive on <i>6/27</i> 1956, and that death occurred at <i>4:45 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George H. McLean</i>		ADDRESS (Street, city or town, state) <i>1746 K. St. N.W. - Wash - D.C.</i>	
PHYSICIAN'S NAME (Type) <i>George H. McLean, M.D.</i>		DATE SIGNED <i>6/27/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/30/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley Funeral Home</i>		24. REC'D BY REGISTRAR <i>W. W. R. R. R.</i>	
ADDRESS <i>3200 R. I. Ave. N. R. R. R.</i>		24b. REGISTRAR'S SIGNATURE <i>W. W. R. R. R.</i>	

RECEIVED

JUL 2 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
100-105
CERTIFICATE OF DEATH
0278

NAME OF DECEASED: *John Doe*
AGE: *45*
SEX: *Male*
DATE OF BIRTH: *11/24/11*
PLACE OF BIRTH: *John Doe, Maryland*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *7/1/56*
PLACE OF DEATH: *John Doe, Maryland*
SIGNATURE OF PHYSICIAN: *John Doe*
SIGNATURE OF REGISTRAR: *John Doe*
DATE OF REGISTRATION: *7/2/56*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6477 CERTIFICATE OF DEATH

06493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md.</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Victoria Estadio Spencer</u>				4. DATE OF DEATH <u>June 21, 1956</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1933</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis Emory Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Helen E. Henson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Helen E. Henson</u>				Address <u>Croome Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia. Pulmonary Congestion & Edema</u> 415X DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Acute Rheumatic Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hours.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-8</u> , 19 <u>56</u> to <u>June 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Roth</u> M.D.				ADDRESS (Street, city or town, state) <u>Dover Md.</u>			
PHYSICIAN'S NAME (Type) <u>Albert Roth</u>				DATE SIGNED <u>6-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>6-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Simons</u>		22d. LOCATION (City, town, or county) (State) <u>Croome Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington + Son</u>				ADDRESS <u>467 N. St. N.W. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u></u>				24b. REGISTRAR'S SIGNATURE <u></u>			

A34
DP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06494	
I have a Maryland license										Reg. Dist. No. 242	
6518										CERTIFICATE OF DEATH	
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland					c. LENGTH OF STAY IN 1b Suitland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4606 Porter Avenue					d. STREET ADDRESS 4606 Porter Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBIN EDGERTON SPENCER					4. DATE OF DEATH Month June 3, Day 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 23, 1896		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Weather Bur					10b. KIND OF BUSINESS OR INDUSTRY Ogden, Utah					11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME William Spencer					14. MOTHER'S MAIDEN NAME Nellie C. Spencer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI					16. SOCIAL SECURITY NO.					17. INFORMANT Address 4606 Porter Ave Carolyn C. Spencer, Daughter Suitland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac failure or Coronary Artery Disease (b) Carotid artery Disease 5 yrs. (c) Heart greatly enlarged 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town)				(County) (State)			
21. I certify that I attended the deceased from July 10, 1953, to May 11, 1956, that I last saw the deceased alive on May 11, 1956, and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. B. Glenn M.D. 2015 Q Street N W											
ACTUAL SIGNATURE J. B. GLENN											
PHYSICIAN'S NAME (Type) J. B. GLENN 2015 Q Street N W											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/7/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph Gunkel's Sons 1756 Pa. Ave., D.C.											
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE June 6-56 Carrie Campbell											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6478

CERTIFICATE OF DEATH

Reg. Dist. No. 47541

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Ged.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesleys Ind.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>6312 X St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Spriggs</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1956</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Charles Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Delores Spriggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>			
17. INFORMANT <u>mother - as above.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 8, 1956</u> , to <u>June 13, 1956</u> , that I last saw the deceased alive on <u>June 13, 1956</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				DATE SIGNED <u>June 13, 1956</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>July 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Park</u>				22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Perkins</u>				ADDRESS <u>—</u>			
24a. REC'D BY REGISTRAR <u>—</u>				24b. REGISTRAR'S SIGNATURE <u>—</u>			

CERTIFICATE OF DEATH

1953

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF WITNESSES		11. SIGNATURE OF CORONER		12. SIGNATURE OF BURIAL OFFICIAL	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERMENT	
19. SIGNATURE OF BURIAL		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
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100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. 2

JUL 12 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06495

6519

Item 13, Film 198 6-18-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Chickasaw	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN lb 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Hall		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Junior Summerall		4. DATE OF DEATH June 3 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1926
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Georgetown, Alabama U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnny Henry Summerall		14. MOTHER'S MAIDEN NAME Henryetta Dees	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Airforce Records, Bolling Field		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3533 SUFFOCATION DUE TO Epileptic Convulsion during sleep Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF June 5, 1956	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Mobile Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page One of Two

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Director		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Interment		18. Signature of Burial	
19. Signature of Burial		20. Signature of Burial		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
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100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

BUREAU V. S.

JUN 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7, Film 199 7-5-56 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6479

06496

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Hts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 6402 Lee Pl.			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Taylor				4. DATE OF DEATH Month Day Year June 25 1956			
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1996 Unknown	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Clea Wells 1000 60th Ave NE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Uremia DUE TO (b) Nephrosclerosis DUE TO (c) Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> gemischte Arterio-sclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-23, 1956, to 6-25, 1956, that I last saw the deceased alive on 6-25, 1956, and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Roth M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Albert Roth							
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-2-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.S. Washington & Son 467 N. St. Md				24a. REC'D BY REGISTRAR DATE 2-19-56 24b. REGISTRAR'S SIGNATURE			

Nov. 231

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>July 1, 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>July 1, 1911</i>		11. TIME OF BIRTH <i>10:00 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF PHYSICIAN <i>Dr. John Doe</i>		14. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		15. NAME OF NURSE <i>Miss Smith</i>	
16. NAME OF CORONER <i>Mr. Jones</i>		17. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		18. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
19. NAME OF FUNERAL HOME <i>Mr. White</i>		20. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		21. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
22. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		23. NAME OF MINISTER <i>Rev. Mr. Brown</i>		24. NAME OF FUNERAL HOME <i>Mr. White</i>	
25. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		26. NAME OF MINISTER <i>Rev. Mr. Brown</i>		27. NAME OF FUNERAL HOME <i>Mr. White</i>	
28. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		29. NAME OF MINISTER <i>Rev. Mr. Brown</i>		30. NAME OF FUNERAL HOME <i>Mr. White</i>	
31. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		32. NAME OF MINISTER <i>Rev. Mr. Brown</i>		33. NAME OF FUNERAL HOME <i>Mr. White</i>	
34. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		35. NAME OF MINISTER <i>Rev. Mr. Brown</i>		36. NAME OF FUNERAL HOME <i>Mr. White</i>	
37. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		38. NAME OF MINISTER <i>Rev. Mr. Brown</i>		39. NAME OF FUNERAL HOME <i>Mr. White</i>	
40. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		41. NAME OF MINISTER <i>Rev. Mr. Brown</i>		42. NAME OF FUNERAL HOME <i>Mr. White</i>	
43. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		44. NAME OF MINISTER <i>Rev. Mr. Brown</i>		45. NAME OF FUNERAL HOME <i>Mr. White</i>	
46. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		47. NAME OF MINISTER <i>Rev. Mr. Brown</i>		48. NAME OF FUNERAL HOME <i>Mr. White</i>	
49. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		50. NAME OF MINISTER <i>Rev. Mr. Brown</i>		51. NAME OF FUNERAL HOME <i>Mr. White</i>	
52. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		53. NAME OF MINISTER <i>Rev. Mr. Brown</i>		54. NAME OF FUNERAL HOME <i>Mr. White</i>	
55. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		56. NAME OF MINISTER <i>Rev. Mr. Brown</i>		57. NAME OF FUNERAL HOME <i>Mr. White</i>	
58. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		59. NAME OF MINISTER <i>Rev. Mr. Brown</i>		60. NAME OF FUNERAL HOME <i>Mr. White</i>	
61. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		62. NAME OF MINISTER <i>Rev. Mr. Brown</i>		63. NAME OF FUNERAL HOME <i>Mr. White</i>	
64. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		65. NAME OF MINISTER <i>Rev. Mr. Brown</i>		66. NAME OF FUNERAL HOME <i>Mr. White</i>	
67. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		68. NAME OF MINISTER <i>Rev. Mr. Brown</i>		69. NAME OF FUNERAL HOME <i>Mr. White</i>	
70. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		71. NAME OF MINISTER <i>Rev. Mr. Brown</i>		72. NAME OF FUNERAL HOME <i>Mr. White</i>	
73. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		74. NAME OF MINISTER <i>Rev. Mr. Brown</i>		75. NAME OF FUNERAL HOME <i>Mr. White</i>	
76. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		77. NAME OF MINISTER <i>Rev. Mr. Brown</i>		78. NAME OF FUNERAL HOME <i>Mr. White</i>	
79. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		80. NAME OF MINISTER <i>Rev. Mr. Brown</i>		81. NAME OF FUNERAL HOME <i>Mr. White</i>	
82. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		83. NAME OF MINISTER <i>Rev. Mr. Brown</i>		84. NAME OF FUNERAL HOME <i>Mr. White</i>	
85. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		86. NAME OF MINISTER <i>Rev. Mr. Brown</i>		87. NAME OF FUNERAL HOME <i>Mr. White</i>	
88. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		89. NAME OF MINISTER <i>Rev. Mr. Brown</i>		90. NAME OF FUNERAL HOME <i>Mr. White</i>	
91. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		92. NAME OF MINISTER <i>Rev. Mr. Brown</i>		93. NAME OF FUNERAL HOME <i>Mr. White</i>	
94. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		95. NAME OF MINISTER <i>Rev. Mr. Brown</i>		96. NAME OF FUNERAL HOME <i>Mr. White</i>	
97. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		98. NAME OF MINISTER <i>Rev. Mr. Brown</i>		99. NAME OF FUNERAL HOME <i>Mr. White</i>	
100. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		101. NAME OF MINISTER <i>Rev. Mr. Brown</i>		102. NAME OF FUNERAL HOME <i>Mr. White</i>	

RECEIVED
JUL 2 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06497

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capital Heights</u>				c. LENGTH OF STAY IN lb <u>Dead on arrival</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>City Hall</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>Leah</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1926</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Charles E. Foreman</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude McKinney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Charles E. Taylor, same address as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asthma</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. W. Redrich</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

Section 1: Identification

Name: *James E. Taylor*
Date: *April 1, 1956*
Time: *10:30 AM*
Place: *Home*

Section 2: Medical History

History of Present Illness: *Acute myocardial infarction*
Past Medical History: *None*
Family History: *None*
Social History: *None*

Section 3: Physical Examination

General: *Good*
Vital Signs: *Normal*
Heart: *Normal*
Lungs: *Normal*
Abdomen: *Normal*
Extremities: *Normal*

Section 4: Cause of Death

Immediate Cause: *Acute myocardial infarction*
Underlying Cause: *None*
Contributing Cause: *None*

Section 5: Signature and Certification

Signature: *James E. Taylor*
Certification: *True and correct*

BUREAU V. B.

UN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2704 CREST AVE</u>		d. STREET ADDRESS <u>2704-Crest Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARUNAH EUGENE THOMAS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 23 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28-1892</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI</u>	
11. BIRTHPLACE (State or foreign country) <u>FREDERICK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MILTON P THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE M DUTROW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MARY M THOMAS</u>		Address <u>2704-Crest Ave Cheverly MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 10, 1954</u> , to <u>June 23, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Donn Comen</u>		ADDRESS (Street, city or town, state) <u>3503 Penny St Mt Rainier Md</u>	
PHYSICIAN'S NAME (Type) <u>NONMAN DONN COMEN</u>		DATE SIGNED <u>6/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Seventland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lee & Sons</u>		24. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>300-4 4th St NE Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. 1126</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

City of

2704-Central Ave

Chesapeake

Maryland Prince George's

Male White

Cab Driver Taxi

Milton P Thomas

No No

March 28-1942

Frederick Md

Lillie M. Thomas

Mary M. Thomas Chesapeake Md

Generalizing of Anterior 6 to 10 years

June 10 1942

1942

June 10 1942

BUREAU V. B.

Received from (Name) 3203 June 10 1942

RECEIVED

6520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14, Film G198 6-15-56 et

Reg. Dist. No. 240

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>			
c. LENGTH OF STAY IN 1b <u>6 mo</u>				d. STREET ADDRESS <u>Croome Airport Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Croome Airport Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marrington Thompson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6</u> yrs. <u>95</u>	
9. AGE (In years, last birthday)		IF UNDER 1 YEAR Months <u>9</u> Days <u>11</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Wesley L. Bass, Son of #2</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Home</u>		22d. LOCATION (City, town, or county) (State) <u>va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Trayer's Funeral Home</u>				ADDRESS <u>389 R. 2 Ave NW</u>		24a. REC'D BY REGISTRAR <u>June 11, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John L. Danner</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
DEPT. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL		PHYSICAL		LABORATORY	
POST-MORTEM		AUTOPSY		TOXICOLOGY		BACTERIOLOGY		HISTOLOGY	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF JURY		DATE OF JURY		PLACE OF JURY		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF JUDGE		DATE OF JUDGE		PLACE OF JUDGE		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF CLERK		DATE OF CLERK		PLACE OF CLERK		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF ATTORNEY		DATE OF ATTORNEY		PLACE OF ATTORNEY		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MINISTER		DATE OF MINISTER		PLACE OF MINISTER		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF CHURCH		DATE OF CHURCH		PLACE OF CHURCH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF FUNERAL HOME		DATE OF FUNERAL HOME		PLACE OF FUNERAL HOME		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF BURIAL		DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF INTERMENT		DATE OF INTERMENT		PLACE OF INTERMENT		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF CREMATION		DATE OF CREMATION		PLACE OF CREMATION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF OTHER		DATE OF OTHER		PLACE OF OTHER		CAUSE OF DEATH		MANNER OF DEATH	

BUREAU V. 2

UN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6482 CERTIFICATE OF DEATH

Reg. Dist. No. 237

06501

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chelsey, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Coral Gables	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General		d. STREET ADDRESS 114 Antilla Ave. Apt. 2	
3. NAME OF DECEASED (Type or print) Baby Rebecca Leigh Todd		4. DATE OF DEATH Month June Day 10 Year 19 56	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Todd, Troy		14. MOTHER'S MAIDEN NAME Salute, Florence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT mother - as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/9/1956 to 6/10/1956, that I last saw the deceased alive on 6/10/1956, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hault St., Hyattsville, Md.	
PHYSICIAN'S NAME (Type) John W. Perkins		DATE SIGNED 6/12/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF June 1956	22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery	22d. LOCATION (City, town, or county) (State) Chelsey, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE J. W. Boardman	

2077231XV0

NEWLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V.

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66502

6483

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>615 - 61st Ave. S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Tyler</u> Last <u>Tyler</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 1 - 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Almest Sand & Gravel</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-10-3008</u>	
17. INFORMANT <u>Miss Mary Tyler</u>		Address <u>615 61st Ave. Capt. Hgts. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Intest. obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 3, 1957</u> to <u>June 5, 1957</u> , that I last saw the deceased alive on <u>June 5, 1957</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D. <u>Capitol Hgts Md.</u>		DATE SIGNED <u>6/5/57</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Shutland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		ADDRESS <u>6-517-1135 SE. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>6-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Corrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH June 6, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Prison, Nashville, Tennessee	
7. CAUSE OF DEATH Suicide by hanging		8. MANNER OF DEATH Homicide		9. MEDICAL HISTORY None	
10. SIGNATURE OF PHYSICIAN J. Edgar Hoover		11. SIGNATURE OF CORONER J. Edgar Hoover		12. SIGNATURE OF WITNESSES J. Edgar Hoover	
13. SIGNATURE OF DECEASED James Earl Ray		14. SIGNATURE OF NEXT OF KIN None		15. SIGNATURE OF BURIAL OFFICIAL None	
16. SIGNATURE OF REGISTRAR J. Edgar Hoover		17. SIGNATURE OF CLERK J. Edgar Hoover		18. SIGNATURE OF CHIEF OF POLICE J. Edgar Hoover	
19. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		20. SIGNATURE OF JUDGE J. Edgar Hoover		21. SIGNATURE OF SHERIFF J. Edgar Hoover	
22. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		23. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		24. SIGNATURE OF JURY J. Edgar Hoover	
25. SIGNATURE OF PROSECUTOR J. Edgar Hoover		26. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		27. SIGNATURE OF JUDGE J. Edgar Hoover	
28. SIGNATURE OF JURY J. Edgar Hoover		29. SIGNATURE OF SHERIFF J. Edgar Hoover		30. SIGNATURE OF CLERK J. Edgar Hoover	
31. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		32. SIGNATURE OF JUDGE J. Edgar Hoover		33. SIGNATURE OF SHERIFF J. Edgar Hoover	
34. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		35. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		36. SIGNATURE OF JURY J. Edgar Hoover	
37. SIGNATURE OF PROSECUTOR J. Edgar Hoover		38. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		39. SIGNATURE OF JUDGE J. Edgar Hoover	
40. SIGNATURE OF JURY J. Edgar Hoover		41. SIGNATURE OF SHERIFF J. Edgar Hoover		42. SIGNATURE OF CLERK J. Edgar Hoover	
43. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		44. SIGNATURE OF JUDGE J. Edgar Hoover		45. SIGNATURE OF SHERIFF J. Edgar Hoover	
46. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		47. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		48. SIGNATURE OF JURY J. Edgar Hoover	
49. SIGNATURE OF PROSECUTOR J. Edgar Hoover		50. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		51. SIGNATURE OF JUDGE J. Edgar Hoover	
52. SIGNATURE OF JURY J. Edgar Hoover		53. SIGNATURE OF SHERIFF J. Edgar Hoover		54. SIGNATURE OF CLERK J. Edgar Hoover	
55. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		56. SIGNATURE OF JUDGE J. Edgar Hoover		57. SIGNATURE OF SHERIFF J. Edgar Hoover	
58. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		59. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		60. SIGNATURE OF JURY J. Edgar Hoover	
61. SIGNATURE OF PROSECUTOR J. Edgar Hoover		62. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		63. SIGNATURE OF JUDGE J. Edgar Hoover	
64. SIGNATURE OF JURY J. Edgar Hoover		65. SIGNATURE OF SHERIFF J. Edgar Hoover		66. SIGNATURE OF CLERK J. Edgar Hoover	
67. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		68. SIGNATURE OF JUDGE J. Edgar Hoover		69. SIGNATURE OF SHERIFF J. Edgar Hoover	
70. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		71. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		72. SIGNATURE OF JURY J. Edgar Hoover	
73. SIGNATURE OF PROSECUTOR J. Edgar Hoover		74. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		75. SIGNATURE OF JUDGE J. Edgar Hoover	
76. SIGNATURE OF JURY J. Edgar Hoover		77. SIGNATURE OF SHERIFF J. Edgar Hoover		78. SIGNATURE OF CLERK J. Edgar Hoover	
79. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		80. SIGNATURE OF JUDGE J. Edgar Hoover		81. SIGNATURE OF SHERIFF J. Edgar Hoover	
82. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		83. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		84. SIGNATURE OF JURY J. Edgar Hoover	
85. SIGNATURE OF PROSECUTOR J. Edgar Hoover		86. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		87. SIGNATURE OF JUDGE J. Edgar Hoover	
88. SIGNATURE OF JURY J. Edgar Hoover		89. SIGNATURE OF SHERIFF J. Edgar Hoover		90. SIGNATURE OF CLERK J. Edgar Hoover	
91. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		92. SIGNATURE OF JUDGE J. Edgar Hoover		93. SIGNATURE OF SHERIFF J. Edgar Hoover	
94. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover		95. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		96. SIGNATURE OF JURY J. Edgar Hoover	
97. SIGNATURE OF PROSECUTOR J. Edgar Hoover		98. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		99. SIGNATURE OF JUDGE J. Edgar Hoover	
100. SIGNATURE OF JURY J. Edgar Hoover		101. SIGNATURE OF SHERIFF J. Edgar Hoover		102. SIGNATURE OF CLERK J. Edgar Hoover	

BUREAU V. 2

JUN 11 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 199 7-3-56 et

6423

CERTIFICATE OF DEATH

Reg. Dist. No. 245

06503

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pr Md. b. COUNTY Pri. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5801-42ave		d. STREET ADDRESS 5801 42nd Ave. 1801-OWENS RD SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First RHODA Middle WALDRON Last OWENS		4. DATE OF DEATH Month JUNE Day 22 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30-1874
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME CHARLES A. COBURN		14. MOTHER'S MAIDEN NAME MARTHA J. OWENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT LILLIAN E DONALDSON		Address DAUGHTER	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-21 , 19 56 , to 6-22 , 19 56 , that I last saw the deceased alive on 6-21 , 19 56 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE A. Deitz	DATE SIGNED Hyattsville, Md.
PHYSICIAN'S NAME (Type) ARON DEITZ, M.D.	

22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF 6-25-56	22c. NAME OF CEMETERY OR CREMATORY Glenwood	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Lee & Sons		24a. REC'D BY REGISTRAR June 26 1956	24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe

CERTIFICATE OF DEATH

0033

June 30-1914

WHITE

Strawberry

BUREAU V. A.

JUN 27 1956

RECEIVED
JUN 27 1956

Strawberry
June 30-1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,7, File 6199 6-29-56 et

66504

6484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE MD b. COUNTY Pst	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charles 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stair Mount Hts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Wells		4. DATE OF DEATH 6-12-56	
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wells Sr.		14. MOTHER'S MAIDEN NAME Clea McHawran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Thomas Wells Sr.		Address 1000 60th Ave	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Vremia DUE TO (b) nephritis, chronic DUE TO (c) Diabetes mellitus - childhood		INTERVAL BETWEEN ONSET AND DEATH 1 month 5 yrs unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral total blindness - diabetes retinitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Upper Marlboro Md		(County) (State)
21. I certify that I attended the deceased from 5/24, 1956 to 6/12, 1956, that I last saw the deceased alive on 6/12, 1956, and that death occurred at 6 P.M., from the causes and on the date stated above.		
ACTUAL SIGNATURE R. B. Sussex		M.D. 6-12-56
PHYSICIAN'S NAME (Type) R. B. Sussex		DATE SIGNED 6-12-56
22a. BURIAL <input checked="" type="checkbox"/> CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-15-56	22c. NAME OF CEMETERY OR CREMATORY Woodlawn
22d. LOCATION (City, town, or county) Benning Rd. SE. W.C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE R. S. Washington & Son		ADDRESS 467 N. St. NW. Wash. D.C.
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE

RECEIVED

JUN 27 1956

BUREAU V. 31

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESS: [illegible]
12. SIGNATURE OF PHYSICIAN: [illegible]
13. SIGNATURE OF CORONER: [illegible]
14. SIGNATURE OF JUDGE: [illegible]
15. SIGNATURE OF CLERK: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 075552
6485
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Diane Middle Candy Last Wilkerson				4. DATE OF DEATH Month June Day 21 Year 1956			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1956		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Emory Wilkerson				14. MOTHER'S MAIDEN NAME Mary Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT mother as above Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (1000 gms. 38 cm.) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-21 , 19 55 , to 6-21 , 19 55 , that I last saw the deceased alive on 6-21 , 19 55 , and that death occurred at 4:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St, Hyattsville			
PHYSICIAN'S NAME (Type) John W. Perkins				DATE SIGNED June 26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 1956		Prince Georges Annapolis Cheverly Md			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Perkins				ADDRESS Adm		24a. REC'D BY REGISTRAR WKE 12 1956	
						24b. REGISTRAR'S SIGNATURE WKE 12 1956	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
Princess Louise		Female		21		June 1916		London		England		Great Britain		United Kingdom	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
OCCUPATION		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
CAUSE OF DEATH		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
MANNER OF DEATH		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
SIGNATURE OF DECEASED		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
SIGNATURE OF WITNESS		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	
SIGNATURE OF REGISTRAR		None		None		None		None		None		None		None	
None		None		None		None		None		None		None		None	

BUREAU V. S.

JUL 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,13,14 Film G198 6-18-56 et

6486

CERTIFICATE OF DEATH

Reg. Dist. No.

231

06505

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wayside 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince George General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Adaline Last Wise				4. DATE OF DEATH Month June Day 4 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Oct. 1912	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Walter Lorenza Jackson				14. MOTHER'S MAIDEN NAME Susan Adaline Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records				Address Cherely Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 21. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 4-2 , 19 50 , to 6-4 , 19 56 that I last saw the deceased alive on 6-4 , 19 56 , and that death occurred at 11.00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Deitz				M.D. Hottel 6-5-56			
PHYSICIAN'S NAME (Type) A. Deitz M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-7-56		22c. NAME OF CEMETERY OR CREMATORY Baptist - Newberg Md		22d. LOCATION (City, town, or county) (State) Chas. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. ...				ADDRESS 5406 Ill. Ave. SE		24. REC'D BY REGISTRAR DATE 6/6/56	
				24b. REGISTRAR'S SIGNATURE A. H. ...			

CERTIFICATE OF DEATH

8288

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		68		JAN 15 1888		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JUN 10 1956		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		HEART DISEASE		NATURAL		LABORER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956	

RECEIVED
JUN 6 1956
BUREAU V. S.

1

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, Baltimore, Md., this 10th day of June, 1956.

JOHN H. HARRIS, Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6521 CERTIFICATE OF DEATH

06506

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b 59 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marlboro Pike		d. STREET ADDRESS Marlboro Pike	
3. NAME OF DECEASED (Type or print) First Sarah Middle V. Last Wohlfarth		4. DATE OF DEATH Month 6 Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1863
9a. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thos. R. Vessey		14. MOTHER'S MAIDEN NAME Maria Riggles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address Miss Esther Wohlfarth-Forestville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive cardiac failure 442X DUE TO (b) Cardiovascular Renal Disease 1 yr. DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophic arthritis chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Natural Causes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1946 to June 14, 1956, that I last saw the deceased alive on June 12, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul C. Van Natta		DATE SIGNED Washington 28 D.C. 6/14/56	
PHYSICIAN'S NAME (Type) PAUL C. VAN Natta		Washington 28, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/56	
22c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		22d. LOCATION (City, town, or county) Suitland (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE June 18-56		24b. REGISTRAR'S SIGNATURE Edwin F. Gillies	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6487 CERTIFICATE OF DEATH

06507

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>8 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>7516 Brightseat Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Woods</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 56</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>13 June 56</u>		9. AGE (In years last birthday) yrs. <u>8</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Woods</u>						14. MOTHER'S MAIDEN NAME <u>Diane Hoyle</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother - as above</u>				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Osteoporosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June 13, 1956</u> to <u>June 14, 1956</u> , that I last saw the deceased alive on <u>June 14, 1956</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.																					
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D.										ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville, Md.</u>				DATE SIGNED <u>6/14/56</u>							
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>June 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Burial Socy</u>				22d. LOCATION (City, town, or county) (State) <u>Cheverly Md</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins</u>										ADDRESS <u>to Odum</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 29 1956</u>				24b. REGISTRAR'S SIGNATURE <u>d. v. Hedrick</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6488

CERTIFICATE OF DEATH

06508

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 8 A Laurel Hill Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Woods			4. DATE OF DEATH Month June Day 10 Year 19 56				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 June 56		9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas Roy Woods				14. MOTHER'S MAIDEN NAME Marilyn Joyce Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address mother - as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - Birthweight: 1 lb 5 oz. 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 40 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1956, to June 10, 1956, that I last saw the deceased alive on June 10, 1956, and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hans Wodak			ADDRESS (Street, city or town, state) DATE SIGNED M.D. 30-CRIDGE Rd. GREENBELT, Md. 6/11/56				
PHYSICIAN'S NAME (Type) HANS WODAK							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1956	22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) Hyattsville Md -		
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters			ADDRESS 254 Carroll St NW		24a. REC'D BY REGISTRAR DATE 6-12-56		24b. REGISTRAR'S SIGNATURE A. W. Hedrick

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. CITY		13. COUNTY		14. STATE		15. ZIP CODE	
16. NAME OF PHYSICIAN		17. NAME OF HOSPITAL		18. NAME OF NURSE		19. NAME OF ASSISTANT		20. NAME OF ATTENDING	
21. NAME OF FUNERAL HOME		22. NAME OF BURIAL PLACE		23. NAME OF CEMETERY		24. NAME OF INTERMENT		25. NAME OF CREMATION	
26. NAME OF CORPSE		27. NAME OF CLOTHES		28. NAME OF SHOES		29. NAME OF ACCESSORIES		30. NAME OF OTHERS	
31. NAME OF WITNESSES		32. NAME OF JURY		33. NAME OF JUDGE		34. NAME OF CLERK		35. NAME OF RECORDS	
36. NAME OF REGISTRAR		37. NAME OF CLERK		38. NAME OF JURY		39. NAME OF JUDGE		40. NAME OF CLERK	
41. NAME OF REGISTRAR		42. NAME OF CLERK		43. NAME OF JURY		44. NAME OF JUDGE		45. NAME OF CLERK	
46. NAME OF REGISTRAR		47. NAME OF CLERK		48. NAME OF JURY		49. NAME OF JUDGE		50. NAME OF CLERK	
51. NAME OF REGISTRAR		52. NAME OF CLERK		53. NAME OF JURY		54. NAME OF JUDGE		55. NAME OF CLERK	
56. NAME OF REGISTRAR		57. NAME OF CLERK		58. NAME OF JURY		59. NAME OF JUDGE		60. NAME OF CLERK	
61. NAME OF REGISTRAR		62. NAME OF CLERK		63. NAME OF JURY		64. NAME OF JUDGE		65. NAME OF CLERK	
66. NAME OF REGISTRAR		67. NAME OF CLERK		68. NAME OF JURY		69. NAME OF JUDGE		70. NAME OF CLERK	
71. NAME OF REGISTRAR		72. NAME OF CLERK		73. NAME OF JURY		74. NAME OF JUDGE		75. NAME OF CLERK	
76. NAME OF REGISTRAR		77. NAME OF CLERK		78. NAME OF JURY		79. NAME OF JUDGE		80. NAME OF CLERK	
81. NAME OF REGISTRAR		82. NAME OF CLERK		83. NAME OF JURY		84. NAME OF JUDGE		85. NAME OF CLERK	
86. NAME OF REGISTRAR		87. NAME OF CLERK		88. NAME OF JURY		89. NAME OF JUDGE		90. NAME OF CLERK	
91. NAME OF REGISTRAR		92. NAME OF CLERK		93. NAME OF JURY		94. NAME OF JUDGE		95. NAME OF CLERK	
96. NAME OF REGISTRAR		97. NAME OF CLERK		98. NAME OF JURY		99. NAME OF JUDGE		100. NAME OF CLERK	

BUREAU V. S.

JUN 12 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G199 7-9-56 et

86509

6489

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>88 Cheverly</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> <u>15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE Georges County Gen. Hosp.</u>				d. STREET ADDRESS <u>7405 18th Ave. #16</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Matthew</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/1911</u> <u>42</u> yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>4</u> Days <u>29</u> Hours <u>15</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Booker Wright</u>				14. MOTHER'S MAIDEN NAME <u>Dora Mack</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma E. Wright</u> Address <u>7405 18th Ave. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26</u> , 19 <u>56</u> , to <u>June 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>56</u> , and that death occurred at <u>10:05 A.M.</u> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D. <u>6480 N. H. Ave. Takoma Park 12, Md.</u>				6/29/56					
PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Livingston, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Petworth Funeral Home</u> ADDRESS <u>814 - Upshur N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>D. D. D.</u>			

RECEIVED

JUL 5 1956

BUREAU V. S.

ON 9-4553